SB 8-75-11

DEPARTMENT OF THE ARMY SUPPLY BULLETIN

Army Medical Department Supply Information

Headquarters, Department of the Army, Washington, DC 20310-2300 20 November 2002

Effective until rescinded or superseded

REPORTING ERRORS AND RECOMMENDING IMPROVEMENTS

You can improve this publication. If you find any mistakes, or you know a way to improve it, please let us know. Mail your letter or DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to the U. S. Army Medical Materiel Agency, ATTN: MCMR-MMA-O Fort Detrick, MD 21702-5001.

SPECIAL NOTICE

The contents of this edition of the SB 8-75 Series reflect the authorized changes of procedures for the AR 40-61, *Medical Logistics Policies and Procedures*.

Authorization has been given from the Office of the Surgeon General (OTSG) and the U. S. Army Publishing Agency (USAPA) for the incorporation of the information into this Series.

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NOTICE: This is the last issue of the DA SB 8-75 Series to be published for 2002

OVERVIEW

This supply bulletin is contains medical materiel management procedures and guidance. It is designed to augment the policies published in the revised AR 40-61, *Medical Logistics Policies and Procedures* that is currently undergoing final Department of Army staffing. Due to the dynamic nature of medical logistics, particularly since 11 September 2001, this SB will be updated and published each year to keep the procedural guidance current and to facilitate the changes that are necessary in providing timely medical logistics support.

A synopsis of the major changes incorporated in the revised AR 40-61 was published in *SB 8-75-S6*, June 2002. The draft *AR 40-61* may be viewed in its entirety on http://www.medlogspt.army.mil. To access the draft regulation from this site requires users to register on the website. To register simply go to the website and click on "Sign Up For Membership" and complete the user registration information. Ensure that you enter the correct electronic mail address. The website manager will review your user profile and respond with an electronic-mail message when approved. The approval review will be performed within 24 hours.

Once website access is obtained, follow these instructions:

- Log onto the website.
- Click on the "Army" button located in the top bar.
- Select the "E-Programs" button on the Army homepage navigator located on the left sidebar.
- Select "Document Review" from the drop-down menu.
- Select *AR 40-61* from the drop-down menu followed by the desired viewing area/chapter. The "print" button can be used if a hard copy of the selected area is desired.

Until the revised *AR 40-61* is published, the 25 January 1995 version is still in effect. However, where there is a conflict between the procedures and guidance contained in this SB and AR 40-61, *Medical Logistics Policies and Procedures*, 25 January 1995, the SB 8-75-11 will take precedence.

CHAPTER 1. INTRODUCTION

1-1. PURPOSE

This Supply Bulletin (SB) provides procedures and guidance for operating a uniform supply system for all medical logistical units, both Table of Distribution and Allowances (TDA) and Modified Table of Organization and Equipment (MTOE) organizations.

1-2. ABBREVIATIONS

Explanation of abbreviations and terms are contained in the Glossary Section of this SB.

1-3. REQUESTING CLARIFICATION

The chain of command will be used to request clarification of the provisions and requirements in this publication.

a. A memorandum will be use when making a clarification request. The memorandum will include the following:

(1) Page and paragraph in question

(2) Requester's name and Defense Switching Network (DSN) phone number.

(3) Each element in the chain of command receiving a clarification request will try to answer it. The clarification request will be sent to the next higher staff when it cannot be answered. This procedure will assure that available knowledge and skills are used and the quickest possible answer is given. Requests received outside of command channels will be returned through channels.

1-4. REQUESTING DEVIATION AUTHORITY

Deviations from procedures in this SB will be made only with prior approval from Headquarters U.S. Army Medical Command (USAMEDCOM). The DFAS-IN Regulation 37-1 will be used to prepare and process request for deviation from accounting procedures. Requests for deviation or waivers should explain the need for the waiver, how long it will last, how the waiver will help accomplish the mission, and how the end results will be measured. The request should include an opinion by the Medical Command (MEDCOM) legal officer.

CHAPTER 2. MEDICAL LOGISTICS SYSTEMS

2-1. FUNCTIONAL PROPONENT

The Assistant Surgeon General for Force Sustainment has the responsibility in accordance with (IAW) Army Regulation (AR) 5-22 for Functional Proponency for Logistics. OTSG Director of Logistics and U.S. Army Medical Command Assistant Chief of Staff for Logistics serves as the Functional Proponent Representative for Medical logistics automated information systems (IS).

2-2. THE ASSISTANT CHIEF OF STAFF FOR LOGISTICS (ACSLOG)

The ACSLOG has primary staff responsibility for logistics in support of the MEDCOM. The ACSLOG is responsible for evaluation and functional proponency of medical logistics systems requirements for command-unique automated logistics systems.

2-3. THE AMEDD (ARMY MEDICAL DEPARTMENT) LOGISTICS SYSTEMS DIVISION

a. The Division plans, develops, and manages AMEDD automated medical logistics information systems, technologies, and programs. The Division is responsible for the life cycle management of medical logistics systems and has funding responsibilities to include: programming, justification, and acquisition strategy. The division asserts AMEDD functional proponency for emerging automated materiel management systems through review of project documents, feasibility studies, and development of systems proposals.

b. The AMEDD Logistics Systems Division provides guidance to subordinate commands and MHS proponency groups and conceptualizes and implements new and emerging technologies to enhance medical logistics business processes and automated medical logistics systems.

c. The AMEDD Logistics Systems Division oversees the integration and joint interoperability of automated materiel management systems to ensure viable logistics support to the AMEDD and its readiness mission. Consistent with Department of Defense/Department of the Army (DoD/DA) doctrine, the Division ensures AMEDD efforts are integrated with evolving worldwide medical management, financial and training systems.

2-4. MEDICAL LOGISTICS AUTOMATED INFORMATION SYSTEMS (IS)

This paragraph applies to medical logistics IS at automated medical logistics operations, medical fixed facilities, division, and corps level units (Echelon II-V). This paragraph is in accordance with AR 25-1.

a. Medical logistics ISs will support the following core business functions:

(1) Acquisition, accountability, and distribution of materiel and equipment.
(2) Use, maintenance, and repair of facilities supporting the AMEDD medical mission.

b. Army medical fixed facilities and units conducting medical logistics operations will use existing DoD/Army standard medical logistics IS. Units will migrate to future DoD/Army ISs when they are approved and implemented.

c. Medical fixed facilities and units conducting medical logistics operations will not use locally developed or procured non-standard medical logistics systems when either a DoD or standard Army management information system (STAMIS) is available.

d. Units and supply activities at all levels will promote the use of electronic ordering for all Class VIII transactions through the available and approved Medical Logistics IS. Specifically, the Installation Medical Supply Activities (IMSA) located at the MEDCOM fixed facilities will mandate the use of Medical IS to establish electronic ordering with all customers. Hardcopy or manual requisitions will be the exception. The habitual use of electronic ordering will improve efficiency and effectiveness for both peacetime and wartime operations. Ongoing guidance from the MEDCOM to the IMSA will establish electronic ordering procedures.

2-5. MEDICAL LOGISTICS INFORMATION SYSTEMS (IS) DEFINITIONS

a. The following systems are authorized as standard DoD and Medical Logistics Management ISs:

(1) Theater Army Medical Management Information System (TAMMIS): There are three TAMMIS logistics modules. TAMMIS is maintained by the:

US Army Medical Information Systems and
Services Agency (USAMISSA)
ATTN: Acquisition Management Division, Logistics
2455 N. E. Loop 410, Suite 150
San Antonio TX 78217

(a) TAMMIS Modules.

(1) Medical Supply (MEDSUP): Automated and comprehensive inventory management of medical materiel.

(2) Medical Maintenance (MEDMAINT): Automated management of scheduled maintenance and repair of medical equipment.

(3) Medical Assemblage Management (MEDASM): Automated management of medical assemblages.

(b) TAMMIS Customer Assistance Module (TCAM): TCAM allows remote customers who have no other medical logistics automation to create automated Class VIII requests with minimal hardware requirements (PC or laptop and a modem). TCAM customers can dial in to the designated TAMMIS site and select files from the TAMMIS database. Once the files are downloaded, the customer

can break the connection and use the TAMMIS data to place orders, check status, review the stockage catalog, and research substitutions. Then, customers can dial back in and send the file containing Military Standard Requisitioning and Issue Procedures (MILSTRIP) transactions to the TAMMIS source of supply. TCAM has been successfully used in garrison and in deployments. Units are strongly encouraged to use TCAM in order to establish electronic Class VIII ordering with the designated source of supply. TCAM is an approved part of the TAMMIS baseline: Units will contact the TAMMIS Project Office Customer Support Office at 210 295-8533

(c) Communications: TAMMIS can relay information between Table of Organization and Equipment (TO&E) units in various ways. The preferred methods use Tactical Terminal Adapter (TTA) or Local Area Network (LAN). Both methods rely on the use the Mobile Subscriber Equipment (MSE) military communications system. Because communications cannot be assured in wartime, units can also pass information by standard telephone lines, Defense Data Network (DDN), International Maritime Satellite (INMARSAT) using a commercial modem, over a stand-alone LAN (without MSE), by high frequency (HF) radio, or by floppy diskette or tape delivered by courier. All methods preclude re-entering data at the receiving TO&E unit. TAMMIS data that must be transferred includes transactions and files that are moved by File Transfer Protocol (FTP), modem (Unix to-Unix Copy Protocol (UUCP) and Blocked Asynchronous Transmission Protocol (BLAST)), HF Radio, floppy disks or paper. Examples of transactions and files that are moved include medical logistics MILSTRIP transactions (requisitions, supply status, shipment status, follow-up transactions, requisition modifiers, and cancellation requests). TAMMIS logistics systems also pass electronic commerce transactions to vendors who only have dial-up capability. The system is designed to utilize all forms of communications available to a unit in garrison and in a deployed environment.

(2) Army Medical Department Property Accounting System (AMEDDPAS): Primary IS for planning, acquiring, establishing, maintaining formal accountability, and maintenance of medical equipment in TDA facilities and installations.

(3) Defense Medical Logistics Standard Support (DMLSS): DoD migration IS to replace TAMMIS and AMEDDPAS.

b. The following systems are authorized as standard DoD and Army Logistics Management ISs:

(1) Purchase Request Web (PRweb): Web enabled application to create, modify and route paperless purchase requests to the contracting Procurement Desktop-Defense (PD^2), which supports the Standard Procurement System (SPS).

(2) Defense Blood Bank System (DBBS): DBBS automates the blood bank operations and is currently fielded to MEDLOG units, deployable and fixed hospitals with a blood bank/donor center support mission. This application will be integrated as part of the Theater Medical Information Program (TMIP) suite of software to support the Forward Support Medical Company (FSMC), Main Support Medical Company (MSMC), Medical Logistics (MEDLOG) units, and deployable hospitals in the corps and echelons above corps (EAC) levels.

(3) Spectacle Request Transmission System (SRTS): SRTS automates the patient record portion of the optical prescription and order transmission process to Medical Logistics (MEDLOG) units and Optical Fabrication Laboratories in the corps and Echelons Above Corps (EAC) levels.

(4) Global Combat Support System -Army (GCSS-A) Maintenance (MNT): GCSS-A-MNT is the replacement for the Unit Level Logistics System-Ground (ULLS-G) that will be used in all Battalion Aid Stations (BAS), Forward Support Medical Company (FSMC), and Main Support Medical Company (MSMC) at Echelon I, II, and selected III units. GCSS-A-MNT will also be the migration system for all MEDLOG units using TAMMIS MEDMAINT, as well as deployable hospitals in corps and EAC levels. GCSS-A-MNT will be used in all medical units authorized a company or battalion level motor maintenance operation in the division, corps, and EAC levels.

(5) GCSS-A Supply and Property (SPR): GCSS-A-SPR is the replacement for the Unit Level Logistics System S4 Module (ULLS-S4) and Standard Property Book System-Redesigned (SPBS-R) systems, that will be used in all medical units at the battalion level and higher that maintain their own property books in the corps and EAC levels.

c. When standard Medical Treatment Facility (MTF) medical logistics systems do not provide the functionality to support a required medical logistics business practice, non-standard ISs are authorized only after approval through the AMEDD Directorate of Logistics/Assistant Chief of Staff for Logistics (DOL/ACSLOG). MTFs shall submit a request for waiver through their respective Regional Medical Commander (RMC) to:

Commander, USAMEDCOM
ATTN: MCLO-LS
2050 Worth Road, Suite 8
Fort Sam Houston TX 78234-6008

d. Army medical activities and units operating a manual medical accounting system will follow this regulation and procedures in AR 710-2, and DA Pamphlet (PAM) 710-2-2.

e. Army medical fixed facilities are authorized to use commercial automated medication and supply distribution systems, known as Point of Use (POU).

(1) Coordination with USAMEDCOM is required to purchase or lease POU systems in order to apply the numerous system interfaces that maximize the benefits of POU cabinets. Requests to purchase or lease POU systems will be submitted through the respective Regional Medical Command (RMC) to:

Commander, USAMEDCOM
ATTN: MCLO-LS
2050 Worth RD, Suite 8
Fort Sam Houston TX 78234-6008

Requesting activities must submit justification that includes projected economic and clinical benefits.

(2) Activities with POU systems will follow prescribed security measures and system requirements for medication management outlined in AR 190-51.

Activities with POU systems will maintain written policies and procedures for security, accountability, and emergency situations.

f. Army medical activities with automatic identification technology (AIT) equipment that includes Radio Frequency (RF) devices, such as base radio units, repeaters, hand-held terminals, scanners, and printers will utilize and maintain the equipment. Trouble calls for AIT equipment in support of DMLSS applications will be submitted to the Military Health Systems (MHS) helpdesk IAW procedures described in paragraph 2-6.

2-6. HELP-DESK

a. Trouble calls for in support of TAMMIS and AMEDDPAS will be submitted to the United States Army Medical Information Systems and Services Agency (USAMISSA), TAMMIS Project Office Customer Support Office at 888 567-2514 or 210 654-2528.

b. Trouble calls for in support of DMLSS will be submitted to the MHS Help Desk at 800 600-9332 [Continental United States (CONUS)], 210 767-5250 (Direct), 866 637-8725 [Outside Continental United States (OCONUS)]. Digital Help request can be made at: **http://www.mhs-helpdesk.com**.

c. A System Change Request (SCR) is an official recommendation to correct or enhance the functionality of AIS. In a formal process, a SCR is validated and accepted by the program manager. Units or activities that have identified a significant problem or possible improvement that may warrant a SCR will submit their ideas to the appropriate project office through the help-desk.

CHAPTER 3. MEDICAL MATERIEL MANAGEMENT

3-1. MEDICAL SUPPLY SUPPORT ACTIVITY (SSA) OPERATIONS

This chapter provides procedures for operation of SSAs and other supply operations for medical materiel.

a. The SSAs for medical materiel are distinguished from other medical supply operations in that they:

(1) Operate a stock record account per AR 710-2
(2) Perform the full range of supply functions identified for SSAs in AR 710-2
(3) Appoint an accountable officer per AR 735-5
(4) Requisition materiel directly from the wholesale system or from a major, intermediate level medical materiel SSA

b. The SSAs for medical materiel include:

(1) Installation Medical Supply Activity (IMSA)

(2) Medical Logistics Battalion (MEDLOG Bn): In peacetime, MEDLOG Bns may perform the full functions of a SSA, may have a training mission, or may have an area supply mission. Upon mobilization and/or deployment, the MEDLOG Bn will normally perform all SSA functions.

(3) U.S. Army Medical Materiel Center Europe (USAMMCE)

c. Other supply operations for medical materiel maintain informal stock control records in support of a direct support or area supply mission. These operations do not normally requisition directly from the Defense Logistics Agency (DLA) system and do not perform the full range of supply and Financial Inventory Accounting (FIA) functions required of a SSA.

d. Other supply operations for medical materiel include:

(1) Combat Division level medical supply support provided by the Division Medical Supply Office (DMSO)
(2) Medical supply detachments
(3) MTOE hospital units with an area supply mission
(4) Other medical units with an area supply mission
(5) Medical Logistics Management Center (MLMC) – The MLMC is a unique organization that currently has a comprehensive and evolving role in REACH Logistics.

3-2. SUPPLY SUPPORT ACTIVITIES

The SSAs for medical materiel provide direct, general, and/or installation support to units and activities within a designated command or area. The unit's or activity's MTOE, TDA, or Major Command (U.S. Army) (MACOM) directive will state the mission for providing this support. The SSA:

a. Maintains accountability and manages medical supply stocks that are stored for issue to authorized supply customers

b. Operates a stock record account per AR 710-2

c. Operates with a standard logistics IS

d. Conducts prescribed FIA and financial management of the:

(1) Defense Wide Working Capital Fund (DWWCF), which finances acquisition of SSA stocks at selected activities

(2) Army fund or Operation and Maintenance, Army (OMA) fund

(3) Defense Health Program (DHP) fund, which finances acquisition and distribution of SSA stocks at selected activities

3-3. INSTALLATION MEDICAL SUPPLY ACTIVITY

a. The IMSA is normally the SSA for medical materiel for a designated installation and/or geographical area and is under the control of the medical center (MEDCEN) or medical department activity (MEDDAC) commander. The IMSA is normally separate from the installation's consolidated supply operation.

b. The MEDCEN or MEDDAC commander provides medical supply support to designated units and activities on the installation and within the assigned geographical support area (see AR 5-9).

c. The medical supply officer (MSO) is responsible to the MEDCEN or MEDDAC commander for operation of the IMSA.

d. The IMSA accountable officer and/or MSO directs the operations of the IMSA. The MSO provides total medical supply support to all supported units and activities. The MSO is responsible for security of materiel per AR 190-51.

e. The IMSAs are authorized direct contact with customers, U.S. Army Medical Materiel Agency (USAMMA), Defense Supply Center Philadelphia (DSCP), other government agencies, supporting medical supply, and local purchase activities on medical supply matters.

f. The MEDCOM IMSAs, under the direction of their RMC, will meet with all supported active and U.S. Army Reserve units at least annually to determine mobilization and deployment requirements.

3-4. MEDICAL LOGISTICS BATTALIONS/U.S. ARMY MEDICAL MATERIEL CENTER EUROPE

a. The MEDLOG Bn/USAMMCE assigned a medical SSA mission supports all customers according to the logistics support plan developed for their command or area of operation. The plan outlines the relationship between the MEDLOG Bn/USAMMCE and their supply support. The CONUS MEDLOG Bns supporting command shall coordinate the logistics support plan with the supporting RMC.

b. The MEDLOG Bn supported by an IMSA must conduct all interfaces with the wholesale system (such as, submission of MILSTRIP replenishment requisitions) through the IMSA unless directed by the IMSA/RMC.

3-5. U.S. ARMY NATIONAL GUARD UNITS

U.S. Property and Fiscal Officers (USPFOs) may provide IMSA-type support to Army National Guard (ARNG) units. The USPFOs and ARNG MTOE units assigned a medical supply support mission will operate per this directive.

3-6. CONSOLIDATED SUPPLY ACTIVITIES ON ARMY MEDICAL DEPARTMENT INSTALLATIONS

a. On Installations, under AMEDD control, other supply commodities may be consolidated with medical into a single activity.

b. The AMEDD installation consolidated supply activities:

(1) Operate under a structure similar to that of the IMSA.

(2) Are authorized, by The Surgeon General (TSG), direct contact with nonmedical supply activities, Service Item Control Centers (SICCs), and National Inventory Control Points (NICPs), as appropriate.

3-7. STOCKAGE

The following activities can stock the listed materiel.

a. The SSAs identified in para 3-1 can stock:

(1) Standard (catalogued) items listed in the Army Master Data File (AMDF) or Federal Logistics Data on Compact Disc (FEDLOG).

(2) Nonstandard items (items listed in the Universal Data Repository (UDR) medical catalog (MEDCAT) on CD-ROM or items required to support the health care mission).

b. The MTOE medical supply operations can stock:

(1) Consumable items authorized in the medical sets, kits, and outfits (SKOs) supported. For MTOE hospitals, the required resupply module fulfills this requirement.

(2) Items used to meet contingency missions, training requirements, or used to provide garrison medical support, if approved by the command surgeon. These units will maintain command surgeon approved authorized stockage lists (ASLs) that reflect both wartime and peacetime requirements.

c. The ARNG units maintain State Surgeon approved formularies.

3-8. VENDOR INVENTORY SERVICE

The IMSA/MEDLOG Bn/USAMMCE can use direct-order and other electronic vendor (INTERNET) inventory services provided by commercial medical materiel distribution organizations. Such services may provide either automatic or on-demand shipment of materiel. The IMSA/MEDLOG Bn/USAMMCE may use these services to augment in-house capabilities for nonstandard items and services. This augmentation provides significant benefits for managing short shelf life items. The IMSA/USAMMCE may also use vendor inventory services as an alternative to stocking and maintaining inventory at the installation level. Where appropriate, the IMSA/USAMMCE may authorize other SSAs (MEDLOG Bn) and customers to use direct-order and other electronic vendor inventory services to satisfy supply requirements.

3-9. STOCKAGE CRITERIA

a. Recurring demands: The IMSA/MEDLOG Bn/USAMMCE must provide responsive support to customers having recurring demands for medical items. Two ways of providing this responsive support are:

- Commercial contract services {commercial distribution contracts/prime vendor (PV)} and/or
- Locally stocked, selected items based on demands

(1) The preferred method is through a commercial contract service, such as the DoD PV program. When using this method, the IMSA/MEDLOG Bn/USAMMCE must coordinate new requirements for recurring items with the supporting commercial distributor.

(2) Local stockage of selected items will be used when:

(a) The commercial distributor is providing unsatisfactory support.

(b) The distance between the IMSA/MEDLOG Bn/USAMMCE and the supporting commercial distributors warrants stocking items to preclude interrupting supply support.

(c) Items are not available through the supporting commercial distributor.

b. Number of recurring demands

(1) The IMSA/MEDLOG Bn/USAMMCE will follow these guidelines when determining stockage.

(a) If six recurring demands have been recorded within a 360-day period, review for stockage.

(b) When less than six recurring demands have been received and when the customer requests in writing that an item be stocked, the SSA may stock the item. Customers may be charged for the unused quantities. The IMSA/USAMMCE should return/dispose of excess quantities.

(c) For emergencies, the Unit's senior logistics officer can approve stockage of items.

(d) Items with at least three recurring demands within a 360-day period may be retained for stockage.

(2) The MTOE medical supply operations will follow these guidelines.

(a) When there are six recurring demands within a 360-day period, establish an initial stockage for the item.

(b) If there are at least three demands within a 360-day period, maintain stockage.

(c) Follow MACOM guidance when establishing stockage criteria for items that support ASLs and Mandatory Parts Lists (MPL) or resupply of medical assemblage components.

3-10. STOCKAGE LISTS

a. The IMSA/MEDLOG Bn/USAMMCE will provide copies of the stockage list to supported activities. Local policy will govern frequency and recipients.

b. The MTOE medical supply operations must maintain ASLs. Local policy will govern the distribution of the ASLs.

3-11. CRITICAL ITEMS

a. The Joint Readiness Clinical Advisory Board (JRCAB) maintains a list of critical items needed for patient care during contingencies. The contents of this list are based on input from the military services and other DoD agencies that manage medical materiel. Periodic analysis of quantities of these critical items held by the military services and other DoD agencies is requested by the Assistant Secretary of Defense for Health Affairs to ensure DoD capabilities will meet contingency requirements.

b. The various Tri-Service Regional materiel standardization committees will review products included on the critical items list to ensure they are considered for standardization at their regional MTFs. The Health Care Activity (HCA) materiel standardization committee works in concert with the RMC to ensure the Tri-Service Region has these items for review and incorporation into the activities' stockage lists.

3-12. STOCKAGE LEVELS

a. Computing reorder points

(1) Compute reorder points with a safety level not exceeding 5 days (15 days for OCONUS) and the actual order and shipping time (OST) for each item. TSG is the approval authority for variable safety levels in automated systems. The OST

for nonstandard items will include the average time used for processing a procurement request.

(2) Compute reorder point using days of supply (DOS) procedures. The DOS method is preferred for distributed/PV items.

(3) Compute reorder point quantities by using economic order quantity (EOQ) procedures (see DA PAM 710-2-2, Appendix D for EOQ Reorder Point with appropriate Safety Level).

b. Computing requisitioning objectives (RO)/levels

(1) DOS is the preferred method for PV items
(2) Use DA PAM 710-2-2 when computing EOQ
(3) The operating level is a maximum of 15 days CONUS (30 days OCONUS) or as determined by the MACOM/command surgeon when establishing the days-of-supply method. Operating levels for nonstandard items acquired under vendor service are based on quantities needed to sustain operations between resupply cycles.

c. Calculating retention levels. When stocks on-hand exceed the RO/level, medical activities will calculate retention levels using provisions of AR 710-2 and DA PAM 710-2-2. Process stocks exceeding authorized retention levels using the excess materiel guidance in this chapter.

d. Calculating stockage levels

(1) The Command Surgeon determines the peacetime stockage objective for the MTOE medical supply operations. The stockage objective should not exceed 90 days.

(2) The MTOE medical supply operations will use the DOS method or the inventory management module of an approved IS to compute the RO/level. Logistics support plans should establish days of supply needed to support designated unit operations when mobilized.

3-13. INVENTORY ACCOUNTING

Use the following accounting methods for stocks. These procedures apply to manual systems and logistics ISs.

a. The IMSA/USAMMCE/MEDLOG Bn maintains accountable records using guidance in AR 710-2, DA PAM 710-2-2, and this SB.

b. Other MTOE medical supply operations will maintain informal inventory accounting records. These records should be maintained per AR 710-2 and DA PAM 710-2-2. Accurate maintenance of these records will maximize efficiency and accuracy of records and effectiveness of training.

c. Medical MTOE units will account for items stocked and for components of medical assemblages.

3-14. REQUISITION PROCEDURES

a. When the commercial distribution contracts/PV or local purchase procedures (Decentralized Blanket Purchase Agreement (DBPA)/Blanket Purchase Agreement (BPA)/Credit Card) cannot fill routine supply requirements, CONUS IMSAs/MEDLOG Bn will submit requisitions to DSCP using MILSTRIP procedures that are delineated in AR 725-50.

b. The MACOM/Command Surgeon will direct OCONUS IMSA/MEDLOG Bn/USAMMCE on submitting requisitions. When commercial distribution contracts or other local purchase procedures (DBPA/BPA/Credit Card) cannot fill requisitions, OCONUS IMSA/MEDLOG Bn/USAMMCE will submit requisitions to DSCP using MILSTRIP procedures that are delineated in AR 725-50.

c. To requisition regulated medical items, follow procedures in this chapter.

d. To requisition provisioned medical equipment items, follow procedures in this chapter.

e. Requisition medical care support equipment (MEDCASE) items by following guidance in SB 8-75-MEDCASE, the USAMMA, and local command publications. The supporting property account will forward MEDCASE requisitions directly to the USAMMA. These requisitions will not be processed through the IMSA/USAMMCE. Other Capital Expense Equipment Program (CEEP) and Capital Expense Medical Equipment Program (CEMEP) items will be direct-fund cited when requisitioned through the medical supply account.

3-15. EMERGENCY REQUISITIONS

a. When emergency or urgent medical materiel requirements exist to save lives or to prevent suffering or distress, IMSA/MEDLOG Bn/USAMMCE will expeditiously process requisitions from supported HCAs using the issue priority designator "03" (life or death) requisitions. Life or death requisitions will be submitted to DSCP only when the item is not available locally. The quantity ordered should reflect the minimum requirements for the particular emergency. Particular attention should be given to customer's requests for in-vitro diagnostics and reagents. Because of the type of materiel involved, activities should be certain that a life or death situation is involved before submitting the requisition on that basis. Non-receipt of incremental shipments is not in itself a justification for submitting a life or death requisition. Submit requisitions telephonically to the Emergency Supply Operations Center (ESOC) at DSCP. Normal duty hour numbers are commercial 215 737-2112 or DSN 444-2112. After duty hour numbers are commercial 215 737-2341 or DSN 444-2341.

The following information, at a minimum, is required on the requisitions:

(1) Name of the physician administering to the patient.
(2) Diagnosis and prognosis of patient(s).
(3) Preferred mode of shipment.
(4) Requisitioner's telephone numbers (duty and after duty) and points of contact.

b. The commander or designated representative will personally review and document all requisitions with an urgency of need designator "A" or "B" per the DA Pam 710-2 series. The IMSA/MEDLOG Bn/USAMMCE will perpetuate all urgency of need designator "A" requisitions from supported activities.

c. Valid exception data for urgency of need designator "A" and "B" requisitions are requests for shipment using:

(1) The fastest traceable means
(2) Shipments by specific mode (i.e., commercial air). If commercial air is requested, IMSA/MEDLOG Bn/USAMMCE will provide an appropriate transportation fund citation. Do not delay life or death "03" requisitions to verify or determine the appropriate fund cite.

d. When MTOE medical supply operations submit emergency urgency of need designator "A" and "B" requisitions to their supporting IMSA/MEDLOG Bn/USAMMCE, the unit commander will authenticate the priority assigned to the requisition per the DA PAM 710-2 series. The MTOE medical supply operation will process emergency requisitions from supported units. The requisition must be properly authenticated, provided the requisitions cannot be filled from on-hand stocks.

3-16. REQUISITIONING STANDARD AND NONSTANDARD MEDICAL MATERIEL

a. Standard stocked items: The OCONUS IMSA/MEDLOG Bn/USAMMCE may transceive an "A01" (request for standard stocked item), "A0A" for CONUS IMSA/MEDLOG Bn, requisitions through the Defense Automatic Address System (DAAS) to the supply source if the requisitions:

(1) Comply with local policies and procedures
(2) Are in MILSTRIP format (See AR 725-50)
(3) Are for medical materiel centrally cataloged by DSCP and listed in either the:

(a) AMDF or FEDLOG
(b) UDR medical catalog (MEDCAT) on CD-ROM

b. Nonstandard nonstocked items: The OCONUS IMSA/MEDLOG Bn/USAMMCE may transceive Document Identifier Code (DIC) "A05" (nonstandard nonstocked items) requisitions through DAAS to the supply source if the requisitions:

(1) Comply with local policies and procedures
(2) Are for medical materiel not listed in either the:

(a) AMDF or FEDLOG
(b) UDR medical catalog on CD-ROM

(3) Are accompanied by all applicable exception data
(4) Are prepared per procedures in AR 725-50

c. Nonstandard medical materiel:

(1) The CONUS IMSA/MEDLOG Bns will purchase nonstandard medical materiel locally. However, when the item cannot be locally obtained, requisitions may be submitted to DSCP citing:

(a) DIC AOE
(b) Pertinent exception data
(c) Advice code "2A"

(2) The MTOE medical supply operations will submit requisitions to their supporting IMSA/MEDLOG Bn/USAMMCE.

3-17. PRIME VENDOR AND ELECTRONIC CATALOG AS A SOURCE OF SUPPLY

a. The overall goal for materiel acquisition is to migrate to greater use of electronic commerce alternatives and decrease reliance on manual, labor-intensive procurements, such as credit cards. Two programs that maximize use of e-commerce methodologies and provide greater system-wide economies are the DSCP PV and the electronic catalog (ECAT) programs.

b. The DSCP pharmaceutical and medical/surgical PVs are the commercial distributors for items, which include:
Distribution and Pricing Agreement (DAPA) items;
Federal Supply Schedule items;
PV non-usage items;
PV committed volume/regional incentive agreements (RIA) items; and
Other e-tool sources.

This program is mandatory for USAMEDCOM activities for products available under the program and serves as the primary acquisition method for pharmaceuticals and medical/surgical materiel.

c. Some actions that can be taken to increase PV utilization by the activity:
(1) Communicate weekly with the PV representative.
(2) Ensure that all non-usage items are ordered under a specific routing identifier code (RIC).
(3) Request items that can be provided by the PV to be stocked if they are not in the PV distribution center.
(4) Review and adjust usage levels with the PV representative monthly.
(5) Continuously review local purchase and credit card purchases with the PV representative for PV eligible items.
(6) Consider utilizing DOS versus EOQ for inventory management.
(7) Order smaller quantities more frequently.

d. Some actions that the activity should ensure the PV is accomplishing to increase utilization:

(1) Weekly communication with the activity.
(2) Notify the activity when usage items are stocked.
(3) Notify the activity when backordered items are received.

(4) Furnish the activity listings of items stocked by the distribution center.

(5) Minimize temporary out of stock. Address the temporary out of stock items routinely (minimum at the weekly meeting) with the activity.

(6) Capture demands on kills/cancellations.

e. Some actions that can be taken to increase by the activity to increase PV fill rate of usage items:

(1) Work rejects daily. Some rejects can be caused or affected by the activity (R2 – Invalid Item Identification; R3 – Invalid Unit of Issue; R6 – Not on Customer Usage List; R7- Reorder as Drop Shipment). The PV should work the other rejects.

(2) Reconcile usage versus non-usage items on a monthly basis with the PV representative.

(3) Order more frequently for smaller quantities.

(4) Do not permit the logistics IS to automatically reorder temporary out of stock or backordered items on a daily basis, if the item cannot be filled by the PV in a reasonable period of time. Such continuous reordering does nothing to obtain the item and increases the number of unfilled/cancelled requisitions, thereby lowering the fill rate.

f. Some actions that the activity should ensure the PV is accomplishing to increase the fill rate:

(1) Notify activity when usage items are restocked (removed from backorder status).

(2) Notify activity when usage candidate is entered as usage in the PV system.

(3) Work with the activity on a daily basis to address rejects that are not caused by the activity (e.g., temporary out of stock, R4 – Manufacturer/National Backorder).

(4) Notify activity when a non-usage item has enough demands to convert to usage.

g. The DSCP ECAT program is used for laboratory, optical, dental, and medical equipment product lines. The program minimizes administrative workload, overhead costs and interest payments by streamlining electronic ordering and financial processes through the Military Standard Billing System (MILSBILLS). This program is mandatory for USAMEDCOM activities for products available under the program.

3-18. REQUISITIONING ITEMS IN SUPPORT OF MEDICAL EVACUATION

a. The USAMMA will publish a list of items required in the medical evacuation system annually in the SB 8-75 series. This list includes a project code to be used when requisitioning these items for use in medical evacuation. During wartime, the

USAMMA may announce additional items through messages and subsequent publications of the SB 8-75 series.

b. Submit requisitions citing the appropriate project code to DSCP. Only requisitions for medical evacuation purposes should cite this project code. The DSCP will fill the requisition from a special pool of assets, when available. The DSCP will also provide the appropriate MILSTRIP supply status. Materiel issued from this pool will consist of used, serviceable stocks rather than new, unused stocks. The DSCP will bill at:

(1) Ten percent (10%) of the standard unit price for those requisitions filled from the special asset pool and for issues of used, serviceable items made to support activities by IMSA/MEDLOG Bns/USAMMCE.

(2) Only ten percent (10%) of the standard unit price for issues of used, serviceable items made to support activities by IMSA/MEDLOG Bns/USAMMCE.

(3) The standard unit price for those requisitions not filled from the special asset pool.

3-19. SHIPMENT DISCREPANCIES

a. When shipments received by the IMSA/MEDLOG Bn/USAMMCE are deficient in quantity or condition, the accountable officer or an alternate will inspect the shipment (see AR 55-38/Navy Supply Instruction (NAVSUPINST) 4610.33/Air Force Regulation (AFR) 75-18/Marine Corps Order (MCO) P4610.19/Defense Logistics Agency Regulation (DLAR) 4500.15, AR 710-2, and AR 735-11-2/DLAR 4140.55/ Secretary of the Navy Instruction (SECNAVINST) 4355.18/AFR 40-54).

b. The manufacturers are only obligated to provide Materiel Safety Data Sheets (MSDS) with the initial shipment of hazardous materials and with the first shipment after an MSDS has been updated. If the MSDS does not accompany a shipment of hazardous materials, the activity must obtain an MSDS from the manufacturer as soon as possible.

c. The PV deficiencies in quantity or condition will be handled per procedures established in the PV statement of work.

d. The IMSA/MEDLOG Bn/USAMMCE will adjust and report any discrepancies. The discrepancy reports most commonly used for medical materiel are as follows:

(1) Standard Form (SF) 361 (Transportation Discrepancy Report - see AR 55-38/NAVSUPINST 4610.33/AFR 75-18/MCO P4610.19/DLAR 4500.15.) This form is:

(a) Used to report damage or loss attributed to a carrier or to improper carrier facilities.

(b) Prepared in coordination with the installation transportation office.

(2) The SF 364 [Report of Discrepancy (ROD)]: Use this form to report supply and packaging discrepancies that are obviously the responsibility of the

supplier or supporting supply activity (see AR 735-11-2/DLAR 4140.55/SECNAVINST 4355.18/AFR 40-54 and AR 12-12/DLAR 4140.60/SECNAVINST 4355.17A/AFR 67-7).

(3) Serious Incident Report: This is used to report theft or suspected theft on high-dollar-value items or controlled substances (see AR 735-11-2/ DLAR 4140.55/SECNAVINST 4355.18/AFR 40-54 and AR 190-40).

e. Distribute copies per the governing regulation.

f. The IMSA/MEDLOG Bn/USAMMCE may request assistance when discrepancies cannot be satisfactorily resolved from:

(1) DSCP
(2) DLA customer assistance teams
(3) USAMMA

g. The MTOE medical supply operations will report supply discrepancies to the supporting IMSA/MEDLOG Bn/USAMMCE per local procedures.

3-20. MATERIEL OBLIGATION VALIDATION

a. The IMSA/MEDLOG Bn/USAMMCE will:

(1) Conduct monthly customer due-out reconciliation (materiel obligation validation (MOV)) with supported customers. The customers must complete a local reconciliation before the quarterly NICP MOV process begins (see AR 725-50).

(2) Review MOV requests with the customers to ensure proper use of funds and the need for continued supply action. Timely response in validating requests from supply sources is essential to ensure ongoing supply action and to prevent cancellation of the request.

b. The MTOE medical supply operations will validate requisitions per local IMSA/MEDLOG Bn/USAMMCE procedures for reconciliation. These MTOE medical supply operations will respond to IMSA/MEDLOG Bn/USAMMCE requests for MOV.

3-21. LOCAL PURCHASE FOR MEDICAL MATERIEL AND SERVICES

The preferred purchasing methodology is the contracted commercial distributor/PV. When the PV is unable to meet the requirement, local purchase may be utilized. The IMSA/MEDLOG Bn/USAMMCE should consider the following when local acquisition of materiel is appropriate.

a. The IMSA/MEDLOG Bn/USAMMCE will use local purchase procedures to satisfy supply requirements of supported customers. Methods of local purchase include:

(1) Direct-order and other electronic (INTERNET) vendor inventory services
(2) Decentralized Blanket Purchase Agreements (DBPAs)

(3) Supporting contracting office where deemed appropriate by the MSO
(4) International merchant purchase authorization card (IMPAC) program/government purchase card/credit card

b. The MTOE medical supply operations will obtain local purchase support through their supporting IMSA/MEDLOG Bn/USAMMCE. The activities should comply with IMSA/MEDLOG Bn/USAMMCE procedures when submitting purchase requests (PRs).

c. The PRs must:

(1) Be made on a competitive basis to the maximum extent possible.

(2) Establish and describe requirements for products and services based on actual needs of the government, not personal preference, and on the minimum essential characteristics required to perform the mission.

d. When government needs are such that only a particular product is acceptable, the customer will attach a justification for other-than-full-and-open competition to the PR. Activities should consider equipment compatibility and other conditions or circumstances that may necessitate sole source procurement. Additional to the factual statement, PRs will include facts concerning test and evaluation of potential products and will identify competitive products to the maximum extent possible. The factual statement should:

(1) Cite the physical, functional, or other characteristics essential to the needs of the government.

(2) Identify the physical and functional characteristics peculiar to the requested product or service.

e. The PRs must include all available information needed to receive the desired materiel. Complete information will prevent unneeded correspondence and will reduce lead-time.

f. Coordination between the customer, supporting medical maintenance activity, and the facility engineer must be accomplished during the planning stage to determine structural and utility requirements for equipment requiring installation.

g. The MSO or designated representative will review all PRs to:

(1) Identify maintenance significant equipment
(2) Determine maintenance requirements
(3) Assist the customer in procurement specifications

h. The PRs for maintenance significant equipment must include a request for two copies of operator and maintenance manuals. The ordering activity can adjust this figure to meet local requirements. Digital or electronic manuals may be provided instead of hard copy manuals.

(1) Operator manuals should include instructions on the following:

(a) Assembly
(b) Operation
(c) Services
(d) Accessories
(e) Calibration, if applicable

(2) Maintenance manuals should include instructions on the:

(a) Assembly
(b) Installation
(c) Troubleshooting
(d) Calibration requirements
(e) Utility schematics/wiring diagrams
(f) Applicable parts requirements

i. The principle assistant responsible for contracting (PARC) is the proponent for the IMPAC credit card program. The USAMEDCOM activities will use only IMPAC cards issued by the USAMEDCOM contracting offices. The USAMEDCOM contracting offices will provide the following types of guidance.

(1) Clarification of advise from the Assistant Secretary of the Army for Research, Development, and Acquisition (ASARDA), to include providing interpretations, clarification, and resolution of conflict between implementing activities and ASARDA.

(2) The USAMEDCOM policies and responsibilities regarding the IMPAC program.

(3) Monitoring and reporting USAMEDCOM progress to ASARDA.

j. Logistical responsibilities are identified in PARC memorandums and implementation plan for purchasing of supplies, equipment, and services.

3-22. UNSATISFACTORY LOCAL PURCHASE SUPPORT

Forward reports of local purchase support that adversely affect the health care mission and cannot be resolved within channels through USAMEDCOM to TSG. The reports should contain:

a. A point of contact
b. A statement of the problem
c. Actions taken to resolve the problem
d. Applicable documentation

3-23. LOCAL PURCHASE OF SELECTED ITEMS OF MEDICAL MATERIEL

The following medical materiel and equipment can be purchased locally.

a. Items, including repair parts required immediately: These items are needed to save lives or prevent suffering and can be purchased by following normal supply and financial procedures. The DFAS-IN Regulation 37-1 authorizes that these

purchases, if necessary, be made in the absence of funds. AR 40-2 outlines the standards for purchasing drugs and immunizing agents.

b. Occupational therapy supplies and equipment: These items are authorized for use by occupational therapists.

c. Professional books and periodicals: These include all library material required by health care personnel involved in direct or indirect patient care.

(1) The OCONUS activities may order medical books and periodicals through DBPAs awarded by DSCP. Send requisitions to DSCP if the required material is not available through DBPAs.

(2) Subscriptions for periodicals and journals may exceed one (1) year when it is more cost effective.

(3) To obtain a limited number of books, the Federal Supply Schedules (FSS) for Federal Supply Group 76 may be used.

d. Wigs (cranial prostheses): These can be supplied to:

(1) Females with alopecia (hair loss)
(2) Males with alopecia

under the following conditions:
(a) Secondary to specialized medical treatment
(b) Along with disfiguring scars
(c) Resulting in psychiatric disorders, and in the medical authority's opinion, the wig would be beneficial therapy.

e. Post-mastectomy prostheses and brassieres. The HCA commander must authorize the post-mastectomy prostheses, brassieres, and wigs as part of the overall course of treatment.

f. Medicinal gases: These can be purchased only when available in satisfactory quality and volume per U.S. Pharmacopoeia standards. Available from:

U.S. Pharmacopoeia
12601 Twinbrook Parkway
Rockville MD 20852
Telephone 800-822-8772

g. Furniture and furnishings for clinical, waiting, and lounge areas.

h. Contact lenses when authorized by AR 40-63/Navy Medical Command Instruction (NAVMEDCOMINST) 6810.1/AFR 167-3.

i. Prosthetic devices, implants, appliances, and accessories (see AR 40-3).

j. The MEDCASE requirements: See SB 8-75-MEDCASE.

k. Prescription safety glasses: Prescription safety glasses are authorized solely for a specific job assignment per AR 40-63, Technical Bulletin Medical 506

(TBMED 506) and Common Table of Allowances (CTA) 50-900. Prescription safety glasses are authorized to members of the uniformed services only on a non-reimbursable basis. Procedures to obtain safety glasses for Federal civilian employees are contained in TB Med 506.

l. Medical research mission or environmental laboratory materiel: The laboratory commander must authorize this materiel.

3-24. SPECIAL DENTAL MATERIEL

a. The DSCP has established indefinite requirements contracts and DBPAs with various companies to purchase prosthodontic supplies, to include:

(1) Artificial teeth
(2) Facings
(3) Backings
(4) Mold guides
(5) Orthodontic supplies
(6) Partial denture casting alloys and accessories
(7) Other dental accessories and materiel

b. Purchase procedures for dental materiel are as follows:

(1) Use of the commercial distribution contracts or DSCP's ECAT program.
(2) Use of DBPAs by activities that provide orthodontic care.

3-25. LOCAL PURCHASE RESTRICTIONS

a. Purchase only Food and Drug Administration (FDA)-approved drugs; exceptions are listed in AR 40-2 and AR 40-7.

b. Do not purchase vaccines and immunizing agents locally unless one or more of the following conditions have been met:

(1) The item is listed in the UDR medical catalog (MEDCAT) on CD-ROM.
(2) The Army has approved or recommended the item for use.
(3) The Surgeon General has specifically approved the item.

c. Do not purchase nonstandard equipment, for which a standard comparable item is available, unless it provides features that are clearly needed in the health care service.

d. Do not purchase standard or nonstandard items needed for facility alterations, additions, expansions, or minor new construction before approval and funding of the construction project.

e. Follow the restrictions contained in the Federal Acquisition Regulation (FAR) and any supplements to purchase items of foreign origin.

f. Purchase infant transport under these conditions:

(1) When transport incubators or bassinets are used solely for ground transport. These items must be FDA approved.

(2) When infant incubators are used for air transport. These items must have been previously approved by the

U.S. Air Force Aeromedical Testing Branch
311 Human Systems Wing/YAML
Bldg. 160, Room 134
2485 Gillingham Drive
Brooks Air Force Base
San Antonio TX 78235-5105

g. Do not purchase or use investigational drugs without the prior written approval from TSG. Submit requests for approval to U.S. Army Medical Materiel Development Activity (USAMMDA):

Commander, USAMMDA
ATTN: MCMR-UMZ
622 Neiman Street
Fort Detrick MD 21702-5009

Army Regulation 40-7 contains additional guidance on investigational drugs.

h. Do not purchase or issue drugs classified "ineffective 1A" by the FDA.

i. Do not purchase regulated medical items (see Glossary) and those authorized in major medical assemblages (SB 8-75 series) without approval of TSG.

j. Purchase orthopedic footwear for authorized individuals using guidance in AR 32-4/DLAR 4235.18/AFR 67-125/NAVSUPINST 4400.70C/MCO 4400.137A, AR 700-84, and AR 40-3.

k. Purchase hearing aids, batteries, and replacement ear molds through the medical supply channels from the Department of Veterans Affairs (DVA) acquisition sources.

l. Do not purchase diagnostic imaging systems unless authorized by the USAMMA.

m. Purchase infant feeding formula using purchase orders, PRs, or BPAs. The IMSA/MEDLOG Bns/USAMMCE may receive formula at no cost as long as the authorized purchase order, PRs, or BPAs call numbers have been processed using prescribed procurement procedures established by the supporting contracting office.

n. Do not purchase investigational equipment not yet certified by the FDA without TSG approval. Submit requests for approval through command channels to

Commander, USAMEDCOM
ATTN: MCLO-O
2050 Worth Road, Suite 8
Fort Sam Houston TX 78234-6100

o. The installation's preventive medicine service, in coordination with the safety committee, will define, develop, and/or review approval procedures for purchasing medical materiel locally. These procedures must mitigate potential harmful health and environmental effects. The MSO will request the MSDS from the manufacturer.

p. Any equipment, supplies, or services offered to the U.S. Government by a contractor on a "no cost" basis will follow the procedures and regulations that are in:

(1) AR 1-100 and AR 1-101

(2) FAR and DoD Federal Acquisition Regulation (DFAR) Supplement (contract or purchase order).

q. The term "no cost" includes:

(1) Equipment, supplies, or services provided as a gift or donation to the government.

(2) Equipment or supplies provided to the U.S. Government for determining suitability for future purchases by the government, whether or not the items are consumed through use.

(3) Equipment temporarily loaned to the government.

(4) Equipment or supplies provided to the government either on a temporary or permanent basis, but conditioned upon purchase.

r. An evaluation must be made to determine total cost to the government under any of the methods described above. The evaluation should include all applicable costs (i.e., consumable supplies, transportation, maintenance, training, site preparation, installation, and associated equipment).

s. If the contracting method is chosen as the most appropriate means of acquiring materiel or services, the following applies:

(1) A valid requirement must exist for the materiel or service.

(2) A provision will be included in the contract concerning the ownership and disposition of the "no cost" equipment and/or supplies in the event the contract is terminated or not renewed.

(3) Administrative or regulatory approvals required for automatic data processing, word processing, office automation system equipment, or MEDCASE will be obtained prior to submission of PRs to the contracting office, whether or not these items are offered at "no cost" to the government.

(4) A PR will be submitted per local procedures to the supporting contracting office. The PR will detail all known costs determined by the evaluation.

t. Property accountability will be established for equipment items either as government-owned or other than government owned, depending on the status of the equipment, upon receipt of the property.

3-26. ACCOUNTING FOR IMPLANTABLE MEDICAL DEVICES

a. Implantable medical devices, such as pacemakers, drug infusion pumps, insulin delivery systems, and similar items, will be requisitioned by the using clinical department from the IMSA/MEDLOG Bn/USAMMCE.

b. Consumer funds/DHP funds will be charged for these items regardless of cost. The items will not be accounted for on the activity property book.

c. A record of the requisition, receipt, and implant of the devices will be maintained by the clinical department requesting the item. This record should be in sufficient detail to meet audit requirements and notification of the patient in case of medical device alert or recall by the manufacturer. The patient's medical record must also be annotated with the appropriate data. Essential elements of information include the patient's name; social security number (SSN); manufacturer, make, model, and serial number of the device; requisition number; and date implanted.

d. The reporting and tracking requirements of 21 Code of Federal Regulations (CFR) applies.

3-27. DEPARTMENT OF VETERANS AFFAIRS (DVA) AS A SOURCE OF MEDICAL MATERIEL

The DVA is a source of medical materiel that is authorized for local purchase. The DVA contracts with firms for common use supplies and services, and these contracts are summarized in FSSs. When making local purchases from a FSS source, follow the provisions in the FAR.

3-28. FUNDING LOCAL PURCHASES

a. Use consumer funds (DHP) to finance local purchase of nonstocked medical supplies and equipment items.

b. For equipment funded through MEDCASE, follow procurement procedures in SB 8-75-MEDCASE.

3-29. RENOVATION OF HEALTH CARE FACILITIES

a. Obtain equipment and furnishings needed to support medical military construction (MILCON) projects by using MEDCASE procedures (see SB 8-75-MEDCASE).

b. Use General Services Administration (GSA) or commercial interior design services to determine entire furnishing requirements and design decor when renovating entire offices or areas. Fund design services from local operating funds.

3-30. DECENTRALIZED BLANKET PURCHASE AGREEMENTS (DBPA)

a. Customers can request the establishment and deletion of DBPAs through the USAMMA with suppliers of medical materiel, equipment, and limited repair parts not otherwise available through a PV or other requirements contract. The USAMMA will forward all requests to DSCP for appropriate action. Primarily, DBPAs assist OCONUS units in obtaining direct access to CONUS suppliers, but CONUS units may also use the DBPAs if authorized. The USAMMA will provide guidance and information on the DBPA program.

b. It is recognized that establishing contractual arrangements such as DBPAs is prudent for emergencies or stock out situations. DBPA purchases are discouraged as a routine method of doing business.

c. Each activity that uses a DBPA must provide a request for nomination of an ordering officer(s) to the USAMMA (COR). Once the USAMMA approves the nominee(s), an original copy of the approval letter will be returned to the activity and DSCP to be maintained on file. The activity must provide accurate and timely information to the supporting agency and the USAMMA regarding changes to the ordering officers list.

d. Each activity will report semi-annual usage and management information through the RMC to the USAMMA. The USAMMA will collate and disseminate this information through USAMEDCOM and DSCP.

e. Customers should request and obtain a status on established DBPAs monthly via electronic mail from the USAMMA. Once an agreement has been established, the customer may begin ordering.

f. The DBPAs are published in the UDR medical catalog on CD-ROM.

3-31. PURCHASING SERVICES AND RENTALS

a. The FAR, as supplemented, provides guidance concerning contracting for personal and non-personal services. Non-personal services may be locally purchased. Examples of non-personal services are as follows:

(1) Repairs to medical equipment when in-house maintenance capability is inadequate.
(2) Installation of equipment when not included with the original contract.
(3) Consultation services.

b. Rent or lease equipment when:

(1) Needed to satisfy an emergency medical requirement.
(2) Available only through lease.
(3) The lease is more cost effective than purchasing.

c. Follow property accountability guidelines for all rented or leased equipment.

3-32. DISPOSITION AND REPLACEMENT CREDIT FOR EXPIRED DRUGS, BIOLOGICALS, AND REAGENTS

a. The IMSA/MEDLOG Bn/USAMMCE can use pharmaceutical returns contracts for expired drugs and biologicals except expired assets of Mark I Kits, CANA, Atropine, 2-PAM, Cipro, Doxy and PBT. These assets need to be reported to the USAMMA, MCMR-MMS-M for disposition instructions. These contracts are with companies who remove expired drugs and biologicals from an activity and obtain credits from pharmaceutical manufacturers for these unserviceable products. The companies then return the credits to PV from which the activity can use for the procurement of new pharmaceuticals. For pharmaceuticals where no credits can be obtained, the company must destroy the unserviceable materiel per Federal, state, and local laws.

b. The IMSA/MEDLOG Bn/USAMMCE will use existing AMEDD-wide pharmaceutical returns contracts. No facility will enter into a local contract for pharmaceutical returns (even if it is more advantageous) without prior coordination with the USAMEDCOM, MCLO-O. The supporting contracting office will award local contracts per procedures in the FAR.

c. The pharmacy service of an HCA can dispose of expired drugs, biologicals, and reagents in one of two ways.

(1) Turn-in expired stocks to the supporting IMSA/MEDLOG Bn/USAMMCE.
(2) Use a pharmaceutical returns contract.

d. Some pharmaceuticals contain constituents that result in products being classified as hazardous waste upon expiration. All activities will determine the appropriate disposal code for the expired products and will dispose of products identified as hazardous through the installation approved hazardous waste disposal procedures.

3-33. STORAGE

a. Storage conditions: Specialized procedures and equipment are required to prevent the deterioration of medical materiel in storage. Medical materiel is frequently sensitive to sunlight, heat, and moisture. Therefore:

(1) Emergency or battery-powered temperature alarm system will be used on refrigerator/freezer storage units at the IMSA/MEDLOG Bn/USAMMCE.

(2) Alarms will be electrically monitored on a 24-hour basis. This can be done manually or through technical design.

(3) Items requiring refrigeration will be stored and shipped at temperatures between 35º and 46º Fahrenheit (F) [2º and 8º Celsius (C)] and frozen items at temperatures below 32º F.

d. The IMSA/MEDLOG Bn/USAMMCE and other medical supply operations will comply with all special instructions on the item, shipping label, manufacturer's literature, UDR or in the Federal Supply Catalog (FSC).

e. X-ray film will be stored per manufacturer's recommended storage methods, usually on edge in a vertical position. Film may fog if stored horizontally.

f. Dry-cell batteries will be removed from instruments prior to storage.

g. Rubber goods will be stored in rolls or laid flat. Talc will be used to separate surfaces.

3-34. STORAGE METHODS FOR IMSAS, MEDLOG BNS, USAMMCE, AND OTHER MEDICAL SUPPLY OPERATIONS

a. Store medical materiel in unit of issue and/or unit of measure. Establish stock control records for both unit of issue and unit of measure items. Determine the unit of measure price by dividing the unit price by the number of units of measure in the unit of issue.

$$\frac{\text{Unit Price}}{\#\text{ of Units of Measure in the Unit of Issue}} = \text{Unit of Measure Price}$$

b. Store controlled items that require special storage and handling procedures to protect against theft per AR 190-51.

c. Store hazardous materiel, including acids, flammables, corrosives, gasses, and poisons per:

(1) TM 743-200-1

(2) TM 38-410/Defense Logistics Agency Manual (DLAM) 4145.11/Navy Supply Publication (NAVSUPPUB) 573/AFR 69-9/MCO 4450.12

(3) AR 200-1

(4) Applicable Federal, state and local laws

d. When storing hazardous materiel, at a minimum, the activities must:

(1) Consider the:

(a) Compatibility of chemicals
(b) Ventilation
(c) Fire protection
(d) Spill prevention and response
(e) Containment
(f) Protection from the weather

(2) Locate an inventory list and all applicable MSDS near the storage area within the HCA.

e. Provide heat, refrigeration, and humidity control where necessary to protect stock (see TM 743-200-1). Physically separate suspended materiel from other stocks and mark with the authority for suspension.

f. Establish stock locator systems, automated or manual, at each storage site to control the use of storage space. Survey all storage locations at least annually, and reconcile survey results with the locator file.

g. Medical supply operations must establish stock locator systems per:

(1) MACOM or Command Surgeon guidance
(2) AR 710-2
(3) DoD 4145.19-R-1

3-35. INVENTORY AND ADJUSTMENT

a. The IMSAs, MEDLOG Bn, USAMMCE, and other medical supply operations must follow procedures in AR 710-2 and AR 735-5, DA PAM 710-2-2 and DFAS-IN Regulation 37-1 when inventorying and adjusting medical stocks.

b. The HCA commanders (Lieutenant Colonel or above) will approve inventory adjustments for IMSAs. Commanders may delegate this authority within the parameters of AR 735-5 or command guidance.

c. The goal for inventory adjustment (gains and losses) is to keep the adjustment below five percent of the RO/level dollar value per fiscal year (AR 735-5).

d. Inventory controlled medical items monthly and account for the items. A disinterested officer appointed on orders will conduct the monthly inventory.

e. The MSO must conduct causative research on all lines having a dollar value adjustment of $1,000 and on all controlled item discrepancies regardless of value.

3-36. ISSUE PROCEDURES FOR SUPPORTED ACTIVITIES OF IMSA/MEDLOG BNS/USAMMCE

a. Organizational elements of TDA HCAs will submit requests for expendable and durable medical materiel to the IMSA/MEDLOG Bn/USAMMCE. Nonexpendable and/or nonmedical materiel requests will be submitted to the property management office. Those activities operating a consolidated supply account, i.e., Walter Reed Army Medical Center (WRAMC), Fort Detrick, and USAMMCE, will submit requests for nonmedical expendable and durable items to their supporting materiel division.

b. Units and activities having an assigned Department of Defense Activity Address Code (DODAAC) will submit requests for expendable, durable, and non-expendable medical items to the IMSA/MEDLOG Bn/USAMMCE per AR 710-2, DA PAMs 710-2-1 and 710-2-2, and MACOM/Command Surgeon guidance. The IMSA/MEDLOG Bn/USAMMCE will arrange for the technical acceptance inspection of maintenance significant equipment before issuing to the requesting activity.

c. Requesting activities will designate personnel authorized to request and receive medical supplies and equipment. A DA Form 1687 (Notice of Delegation of Authority - Receipt for Supplies) will be used for this purpose. Distinction will be made between those authorized to order and receive controlled and sensitive items and other medical materiel. The IMSA/MEDLOG Bn/USAMMCE and other medical supply operations will maintain a current file of completed DA Form 1687s on customers. These procedures are outlined in DA PAM 710-2-1.

3-37. EXCESS EQUIPMENT MANAGEMENT PROGRAM

a. The USAMMA manages the excess equipment management program (EEMP) for the USAMEDCOM. The goals of the EEMP are to:

(1) Eliminate excess medical materiel: Any materiel on-hand and no longer required to satisfy any mission requirement should be considered as excess. Excess materiel must be:

(a) Consumables in condition code "A"
(b) Equipment that is serviceable or economically repairable

(2) Ensure timely and cost effective identification of excess equipment.

(3) Manage excess materiel as a displaced resource that consumes resources and detracts from primary mission accomplishment.

(4) Aggressively report and advertise excess materiel to:

(a) Enhance asset redistribution and use
(b) Reduce disposal requirements

b. The EEMP applies to ARNG, U. S. Army Reserve (USAR), and all AMEDD activities.

3-38. REPORTABLE AND NONREPORTABLE EXCESS MATERIEL

a. The IMSA/MEDLOG Bn/USAMMCE will report excess materiel through the source of supply. To determine what is excess, the reporting activity must compare current, on-hand materiel with active acquisitions and requirements. The TAMMIS/DMLSS is an automated tool for assisting in this process and recommends materiel to be considered as excess.

(1) The USAMMA must approve all lateral transfers of equipment greater than the MEDCASE high dollar threshold.

(2) Equipment less than the MEDCASE high-dollar threshold can be laterally transferred without the USAMMA's approval.

b. Reportable nonexpendable or expendable excess materiel can fall into one of the following categories:

(1) Nonexpendable

(a) Medical equipment with a line item value that is consistent with current MEDCASE high dollar value threshold.

(b) Serviceable nonstandard medical equipment with a line item dollar value of $2,500 or above.

(c) Regulated medical items identified with Acquisition Advice Code (AAC) "A" in the AMDF or FEDLOG. This includes medical equipment sets (MESs) listed in the SB 8-75 series or critical aeromedical evacuation equipment, such as patient monitors, defibrillators, pulse oximeters, and suction pressure apparatuses.

(d) Medical materiel with recoverability codes "D", "K", or "L" regardless of the condition code.

(e) Equipment possessing electrical characteristics unique to a command (220 volts, 50 hertz (HZ)).

(f) Equipment (audiovisual, radioactive, or telecommunications) requiring special disposal procedures.

(g) Automated data processing equipment (ADPE)

(2) Expendable and durable excess medical materiel

(a) Standard or nonstandard with a line item value of $500 or more
(b) Repair parts with a purchase cost of $100 or more
(c) Compressed gas cylinders (see AR 700-68/DLAR 4145.25/ NAVSUPINST 4440.128C/MCO 10330.2C/AFR 67-12)
(d) Aeromedical Evacuation materiel: This materiel could include litters and mattresses, pillows, blankets, litter straps, and patient restraints.

c. The IMSA/MEDLOG Bn/USAMMCE must dispose of or destroy excess materiel not meeting the criteria above. Destruction or disposal can be completed through the use of:

(1) Government awarded pharmaceutical return contracts
(2) Contracts with other DoD medical facilities
(3) Contracts with DVA
(4) Other Government Agencies (National Institute of Health and Public Health Services)
(5) Government awarded disposal contracts
(6) Supporting Defense Reutilization and Marketing Office (DRMO)

d. The IMSA/MEDLOG Bn/USAMMCE will transfer the excess materiel at no cost to the receiving activity. The shipping cost will be borne by the losing activity.

e. Nonreportable excess materiel follows:

(1) Nonexpendable

(a) Uneconomically repairable equipment with no recoverability code
(b) Equipment where the manufacturer no longer exists
(c) Equipment that lacks a model or part number
(d) Equipment that is no longer made or has exceeded its life expectancy (TB MED 7 or manufacturer literature)
(e) Equipment with a condition code "F"

(2) Expendable and durable

(a) Materiel with an expiration date of 3 months or less
(b) Refrigerated and freezer items
(c) Veterinary items

(3) Miscellaneous materiel
(a) Medical books and scientific journals (see AR 40-2): Volumes containing official AMEDD history will be sent to

Director, Center of Military History
ATTN: DAHM-HM
Washington DC 20314-0200

In OCONUS, MTOE units should turn in obsolete, unserviceable excess medical books to the supporting medical facilities with the appropriate MACOM/Command Surgeon approval.

(b) Radioactive materiel (see AR 385-11)
(c) Flags and guidons (see AR 840-10)

3-39. REPORTING EXCESS

a. The IMSA/MEDLOG Bn/USAMMCE must report any reportable excess materiel monthly in the form of a manual or automated report. The AR 725-50 and the AMEDDPAS manual prescribe the codes for the automated report.

b. The RMC/MSCs will establish manual reporting procedures for nonexpendable and expendable excess materiel within their command. The USAMMA will establish manual reporting procedures for the U.S. Army Reserve Command (USARC), ARNG, CONUS, and OCONUS activities not supported by an RMC.

(1) Examples of manual reporting procedures for nonexpendable materiel follow:

(a) For regulated medical items to include MES, include the set control code, estimated dollar value or shortages, and a statement of the set's condition. Aeromedical evacuation materiel and equipment is reported per procedures in AR 40-538/ Department of the Navy Bureau of Medicine and Surgery Instruction (BUMEDINST) 6700.2B/AFR 167-5.

(b) For equipment requiring special disposal procedures, report through the commodities NICP or the responsible governing agency.

(2) The RMC/MSCs will establish manual reporting procedures for expendable materiel. One category of expendable materiel requiring specific

reporting is compressed gas cylinders. These cylinders should be reported for turn-in by using the NSN of an unserviceable (empty) cylinder.

c. The AMEDD TDA activities will use AMEDDPAS to report nonexpendable equipment. The MTOE units will follow guidance from either their MACOM or the USAMMA when using the Standard Property Book System - Redesign. The MTOE can only generate excess nonexpendable equipment through a change of the MTOE authorization document, fielding plans, and/or deployment/contingency.

(1) The Property Book Officer (PBO), when using AMEDDPAS will establish excess property records for reportable excess equipment. These records must be established before the first AMEDDPAS cycle run of each month. The AMEDDPAS captures, categorizes, and combines the excess property records into a consolidated excess equipment report during the first cycle run. This report is provided to the USAMMA for advertising on their website. The USAMMA coordinates the report of excess equipment worldwide for redistribution.

(2) Automation equipment requires specific automated reporting procedures (see AR 25-1). The AMEDD activities will establish an Automation Resources Management Systems account with the Defense Automation Resources Management Program to report excess automation equipment per DoD 7950.1M.

d. The RMC/MSC will require the following information on manual or automated excess reports:

(1) Nomenclature, make, and model number
(2) NSN, if assigned
(3) Date placed in service
(4) Quantity
(5) Line item dollar value
(6) Condition code
(7) Local point of contact

3-40. ADVERTISING EXCESS

a. The RMC/MSC will establish advertising procedures within their health care boundaries for excess equipment and materiel. The RMC/MSC will consolidate and screen all excess reports from their supporting activities. The RMC/MSC will satisfy any requirement within the command during the screening process.

b. The RMC/MSCs will advertise excess materiel distributed throughout the command for no longer than 15 calendar days. If an organization outside of the RMC/MSC command boundaries requests an item on the advertised excess list, the RMC/MSC must request an exception to the redistribution priority scheme from the USAMMA. Lateral transfer procedures will apply (see AR 710-2). After the 15-day period, RMC/MSC will submit the consolidated excess materiel report to the USAMMA.

c. The USAMMA will consolidate the excess reports from the RMC/MSCs. The consolidated excess report will be distributed worldwide for advertisement purposes via message format and the USAMMA's home page. After the 30-day advertisement

period, the IMSA/MEDLOG Bn/USAMMCE can process the unclaimed, unwanted equipment or materiel through DRMO.

3-41. REDISTRIBUTING EXCESS

a. The USAMMA manages excess equipment/materiel redistribution Army wide. The USAMMA will follow the sequence below to redistribute assets.

(1) USAMEDCOM
(2) Other MACOMs
(3) DoD activities
(4) Other Federal agencies
(5) Local redevelopment authority
(6) DRMO

b. The losing activity will:

(1) Notify the gaining activity of the transfer arrangements.
(2) Complete all necessary documentation per AR 710-2 to facilitate the transfer.
(3) Ensure that appropriate maintenance personnel technically inspect the equipment to be transferred. A DA Form 2407 will be completed and sent with the equipment.
(4) Ensure equipment is properly packed, crated and shipped per AR 746-1. The following must accompany the shipped equipment:

(a) Supporting supplies (expendables) and accessories
(b) Repair parts and listing
(c) Operator and technical manuals and manufacturer literature
(d) The AMEDDPAS/TAMMIS/DMLSS or manual maintenance history/records, to include the DA Form 2407

(5) Receive a signed copy of the completed lateral transfer document.
(6) Notify the Resource Management Office to have the Line Item Number (LIN) deleted from the TDA, if applicable.
(7) Delete the property record.
(8) Maintain the lateral transfer documentation for two years.

c. The gaining activity will:

(1) Notify the USAMMA of the requirement for excess equipment/materiel.
(2) Arrange the transfer with losing activity's point of contact.
(3) Upon receipt of the excess equipment:

(a) Inspect transferred equipment for damage and resolve discrepancies with the losing activity. If improper packaging is suspected, notify the USAMMA.

(b) Sign and return a copy of the lateral transfer document to the losing activity within 3 days.

(4) Establish a property book record within 3 days of receipt.

(5) Submit DA Form 2028 (Recommended Changes to Publications and Blank Forms) to their Resource Management Office to add the LIN to the TDA, if applicable.

(6) Maintain accountability for the transferred equipment throughout its life cycle.

3-42. QUARTERLY EXCESS REPORT TO THE U.S. ARMY MEDICAL MATERIEL AGENCY

The RMC/MSCs will report the excess equipment/materiel redistributed through the EEMP to the USAMMA on a quarterly basis. This consolidated excess report is due no later than the 20th of January, April, July, and October of each year. Figure 3-1 shows the proper format for the RMC/MSC consolidated excess report.

QUARTERLY REDISTRIBUTED EXCESS EQUIPMENT/MATERIEL REPORT

Date Prepared _____

Value of reported excess equipment	$_____
Value of redistributed excess equipment	$_____
Distribution of excess equipment/materiel	
Within the RMC/MSC	$_____
Outside the RMC/MSC	$_____
Through DRMO to Other Activities	$_____
To Department of Labor, state, or local facilities	$_____
To USAR or ARNG	$_____
Value of redistributed excess equipment equal to or greater than current MEDCASE high dollar value	$_____
Value of redistributed excess equipment not advertised	$_____
Value of excess equipment turned in to DRMO not listed on excess report	$_____
Value of excess equipment turned in to DRMO and listed on excess report	$_____
Total dollar amount of excess equipment turned in to DRMO	$_____

Figure 3-1. Format of the Quarterly Distributed Excess Equipment/Materiel Report

3-43. DISPOSAL THROUGH DRMO

a. The IMSA/MEDLOG Bn/USAMMCE will manage medical materiel turn in from installation and area activities to the DRMO. Other medical supply operations will turn-in materiel through the IMSA/MEDLOG Bn/USAMMCE to the DRMO. The IMSA/MEDLOG Bns/USAMMCE will establish local procedures to minimize redundant storage and handling of turn-in materiel. When conditions permit, PBOs may

establish equipment turn-in procedures directly to the DRMO, without physically moving the items through the IMSA/MEDLOG Bn/USAMMCE's storage facility. The IMSA/MEDLOG Bn/USAMMCE must approve these procedures. The IMSA/MEDLOG Bn/USAMMCE should process and approve documentation for materiel turn in with condition codes that indicate a continued value to the government. This materiel will move directly from the unit to the DRMO. The PBO may turn in medical equipment with condition codes "H" and "S" directly to the DRMO. The IMSA/MEDLOG Bn/USAMMCE will:

(1) Report the materiel turn-in to the DRMO.
(2) Provide technical assistance to the DRMO as required.

b. The DRMO will process materiel requiring special handling as follows:

(1) Medical materiel that is unserviceable, uneconomically repairable, or otherwise unsuitable for use will be marked
"CONDEMNED - NOT FOR PATIENT CARE."
Medical materiel determined to be hazardous, where the hazardous condition cannot be repaired, will be clearly marked and tagged to state the nature of the hazard. This marking will render the materiel unusable for its intended purpose before turn-in.

(2) Serviceable stock/materiel with lot or batch numbers and an acquisition cost of $500 or more per lot or batch number will be processed according to DoD 4160.21-M. Examples are as follows:

(a) The FSC 6505 - Drugs, Biologicals and Reagents (excluding filled gas cylinders) will **not** be disposed through the DRMO. The IMSA/MEDLOG Bn/USAMMCE may request DRMO assistance in reutilization or donation of non-controlled, non-hazardous drugs following the procedures outlined in DoD 4160.21-M.

(b) The FSC 6510 - Surgical Dressing Materiel

(c) The FSC 6515 - Sutures Only

(3) Compressed gas cylinders will be prepared for turn-in as prescribed in AR 700-68/DLAR 4145.25/NAVSUPINST 4440.128C/MCO 10330.2C/AFR 67-12, prior to transfer to the DRMO. As an alternative, IMSA/MEDLOG Bn/USAMMCE may contract for gas cylinder disposal with vendors who are licensed in accordance with Federal, State, and local laws.

(4) The IMSA/MEDLOG Bn/USAMMCE will retain physical custody of standard and nonstandard pilferable items listed below until disposition instructions are provided by the DRMO.

- Medical items containing recoverable amounts of precious metals. The IMSA/MEDLOG Bn/USAMMCE should precisely mark the items so that disposal personnel may take special handling precautions (see DoD 4160.21-M). Standard pilferable items are identified as Note "M" in the FSC and as Recoverability Code "A" in the AMDF or FEDLOG.

- Standard precious metals. These are identified as Note "R" in the FSC.

- Tax-free alcohol and serviceable hypodermic needles and syringes: Clearly identify before transferring to the DRMO to ensure special processing (see DoD 4160.21-M).

(5) Unexposed medical and dental film, which is not expired, will be disposed through the precious metals recovery program.

c. The MACOM/Command Surgeons will establish property disposal policies and procedures based on local command and DRMO procedures and the above guidelines.

d. Medical materiel eligible for disposal may be designated for training with the HCA commander's approval. Items approved for training use will be clearly identified with a "FOR TRAINING ONLY" label to prevent accidental use on actual patients. Medical personnel must ensure that approved training materiel has been properly disposed after the training mission. Expired drugs, biologicals, intravenous solutions, and reagents may be used for training purposes.

e. To prevent needed medical materiel from being transferred or disposed prematurely, obtain professional guidance from outside Logistics Division, e.g., pharmacy, pathology/laboratory, radiology departments, as to the materiel's further or potential use.

3-44. PRECIOUS METALS RECOVERY PROGRAM

a. The precious metals recovery program (PMRP) provides DoD activities with guidance and the requirements for the identification, accumulation, recovery, and refinement of precious metals from excess and surplus end item, scrap, hypo-solution, and other precious metal-bearing scrap (PMBS). The program's purpose is three-fold:

(1) To promote the economic recovery of precious metals.

(2) To use recovered precious metals for internal DoD purposes or as Government Furnished Materiel (GFM).

(3) To protect the environment from excess discharges of silver concentrations in waste effluent.

b. The PMRP recovers gold, silver, and platinum family metals from excess and surplus property. The platinum family includes platinum, palladium, iridium, rhodium, osmium, and ruthenium.

c. The DLA is responsible for administering and monitoring the PMRP. DoD activities are responsible for program participation, to include the identification and the transfer of PMBS to the local DRMO. The DRMO accumulates and ships PMBS to a recovery contractor for refining. The recovery contractor deposits the refined precious metal to the Defense Industrial Supply Center (DISC) account. The DISC issues the precious metal as government furnished material to government

contractors at a minimal charge in return for an equal reduction in cost for manufacture of government products that use these metals.

d. The U.S.Army Center for Health Promotion and Preventive Medicine (USACHPPM) will insure that MTFs have procedures in place to properly characterize wastes from photo processing (x-ray).

e. The RMC and Command Surgeons will:

(1) Develop a program for the recovery of precious metals by following the guidance in DOD 4160.21-M.

(2) Establish program procedures either as a supplement to SB 8-75-11 or as a separate command regulation for:

(a) Recovering PMBS
(b) Safeguarding recovery equipment and reclaimed scrap
(c) Training using activity personnel
(d) Turn-in of scrap to collection points
(e) Control of the program
(f) Testing of equipment for effectiveness and safety
(g) Disposal of PMBS
(h) Documenting the quantities recovered and their disposition

(3) Establish central collection points at HCAs. These activities will accumulate, report, and ship precious metals and PMBS.

f. Each HCA commander will appoint a Precious Metals Coordinator (PMC) to manage an internal PMRP. At the generator level, at least one Precious Metals Monitor (PMM) will be appointed to ensure the recovery of PMBS within the assigned area of responsibility.

g. Each PMM will assign a document number for each turn in of PMBS, based on local HCA procedures.

h. All high purity gold and silver PMBS will be managed as controlled substances. DA Form 3949 (Controlled Substances Record) will be maintained at the user level to record receipt, issues, and turn-in of PMBS except for fixer solution and scrap film.

i. Each MEDDAC/MEDCEN PMC will maintain a DA Form 1296 for each precious metal and PMBS item.

j. The recovery of silver from spent x-ray film developing solutions is an important element of the program; in some cases the costs to comply with applicable environmental regulations can make recovering the silver uneconomical. Activities may use commercial sources for silver recovery as long as these commercial sources comply with applicable Federal, State, and local environmental laws and regulations.

k. Spent fixer solution should not be discharged to the sanitary sewer system, even after silver recovery processing, unless the silver content of the effluent is less than limits prescribed by the Federal, State, and local laws.

3-45. HAZARDOUS MATERIAL/WASTE MANAGEMENT PROGRAM

a. The AMEDD develops and procures hazardous material in such a way that minimizes potential hazards to public health and the environment. The applicable functions included in this development and procurement are:

(1) Research
(2) Development
(3) Testing
(4) Production
(5) Handling
(6) Use
(7) Storage
(8) Transportation
(9) Disposal

b. The AR 200-1 addresses responsibilities and procedures of the hazardous material/waste management program. The DoD 4160.21-M, AR 420-49 and AR 40-5, and SB 8-75 series define responsibilities and procedures for managing hazardous materials and waste. The Military Item Disposition Instructions (MIDI) and Military Environmental Information Source (MEIS) contain technical guidance for disposal of small, unused quantities of medical materiel, hazardous waste, nonregulated special waste, regulated medical waste (RMW), and excess medical materiel. To obtain this guidance, contact

Commander, USACHPPM
ATTN: MCHB-TS-EHM
5158 Blackhawk Road
Aberdeen Proving Ground MD 21010-5403

If any of these publications contain conflicting guidelines, follow the most stringent.

c. The unit's radiation safety officer will control and manage the disposition of all radioactive waste.

d. The HCA commanders must dispose of non-Resource Conservation and Recovery Act medical, dental, and veterinary supplies, hazardous waste, non-regulated special waste, and RMW (See ARs 200-1 and 40-5 and SB 8-75 series). Commanders must dispose of all materiel and wastes in a manner that:

(1) Protects human health and the environment.
(2) Complies with appropriate Federal, state, local, U.S. Army, and host-nation regulations.

e. The HCA commanders will implement the pollution prevention program to the maximum extent possible. The Army’s goal is to reduce the quantity or volume and toxicity of pollution whenever economically possible. The pollution prevention program’s goals are to minimize the use of disposable items; expand the use of reusable materials and returnable containers; promote the use of minimum packaging; and recycle to the maximum extent practicable. Items that reduce or eliminate pollution will be used or introduced into the system whenever economically possible.

f. Commanders must implement the hazard communication program per 29 CFR 1910.1200 and DoDI 6050.5. The HCA will provide and document appropriate training to persons who manage, use, store, transport, and/or ultimately handle or come into contact with hazardous materiel or waste.

g. The management of hazardous material and waste and RMW will include the following:

(1) Separation of hazardous waste and RMW from the general waste stream at the point of generation. Regulated medical waste mixed with general wastes must be disposed of as RMW.

(2) Recommendation and development of local segregation policies by the infection control committee to the commander per AR 40-5 and Federal, state, and local regulations. Generally, RMW can include:

(a) Cultures and stocks of infectious agents
(b) Associated biological, pathological waste
(c) Blood wastes
(d) All used and unused sharps
(e) Animal waste
(f) Infectious waste

(3) Training of all employees on segregating hazardous waste and RMW.

(4) Maintaining adequate control of all hazardous waste and RMW to prevent unauthorized access.

(5) Collecting, storing, transporting, and disposing of hazardous waste and RMW (See AR 40-5).

(6) Tracking all hazardous waste and RMW from collection to final destination.

3-46. CONTROLLED MEDICAL ITEMS

a. Identification: The Drug Enforcement Administration (DEA) identifies drugs as controlled substances. The Federal Register and the SB 8-75 series contain a list of these drugs and changes that are published annually. The FSC identifies standard controlled substances as Notes "R" and "Q" in the notes column. The AMDF or FEDLOG identify these substances as controlled inventory item codes (CIICs) "R" and "Q."

b. Schedule designations. The DEA assigns controlled substances to one of five schedules depending on the degree of control required.

(1) Schedule I - Substances/drugs having no accepted medical use in the U.S.

(2) Schedule II - Substances/drugs having a high abuse potential with severe psychic or physical dependence liability, identified as:

(a) Note "R" in the FSC.
(b) Controlled inventory item code "R" in the AMDF or FEDLOG.

(3) Schedule III - Substances/drugs having an abuse potential less than Schedules I and II substances, identified as:
(a) Note "Q" in the FSC
(b) Controlled inventory item code "Q" in the AMDF or FEDLOG

(4) Schedule IV - Substances/drugs having an abuse potential less than Schedule III substance, identified as:
(a) Note "Q" in the FSC
(b) Controlled inventory item code "Q" in the AMDF or FEDLOG

(5) Schedule V - Substances/drugs having an abuse potential less than Schedule IV substances, identified as:
(a) Note "Q" in the FSC
(b) Controlled inventory item code "Q" in the AMDF or FEDLOG

3-47. SECURITY PRECAUTIONS FOR CONTROLLED MEDICAL ITEMS

a. Controlled medical items such as controlled substances, tax-free alcohol, precious metals, and other items designated by the HCA commander, require security precautions. Research, development, test, and evaluation facilities will follow the policies and procedures in AR 70-65 when managing controlled substances, ethyl alcohol, and hazardous biological substances.

b. Only those Army Activities identified in the SB 8-75 series can requisition controlled substances from DSCP. The DLA system will ship only to those Department of Defense Activity Address Codes (DODAAC)-cited.

3-48. REQUISITIONING CONTROLLED MEDICAL ITEMS

a. The MACOMs should submit requests for additions and deletions to the list of authorized requisitioners, with justification, through command channels to

Commander, USAMEDCOM
ATTN: MCLO-O
2050 Worth Road, Suite 8
FT Sam Houston TX 78234-6100

b. The USAMEDCOM Commander will:

(1) Advise the submitting command of approved and disapproved requests.

(2) Notify the USAMMA (MCMR-MMB-R) of all approved changes, who in turn, will coordinate with the DSCP. The USAMMA is the originator of the data and is the SICC.

(3) Authorized requisitioners will:

(a) Establish procedures that ensure adequate supply support of controlled substances for satellite medical activities.

(b) Ensure that supported activities demonstrate a valid need for controlled substances before issuing.

(4) Unauthorized units should, if controlled substances are needed, contact the nearest authorized requisitioner for supply support.

(5) The DSCP will reject requisitions from unauthorized activities.

(6) Each month, the DSCP will provide MACOMs with a list of controlled substances issued to their subordinate units. The MACOMs will establish procedures with subordinate activities to reconcile the lists with local supply account records on a timely basis. Subordinate activities must report any discrepancies to MACOMs and the DSCP. In addition, the IMSA/MEDLOG Bn/USAMMCE will establish local procedures to reconcile orders from commercial distributors with actual quantities received.

3-49. LOCAL PURCHASE OF CONTROLLED MEDICAL ITEMS

a. All local purchases of controlled medical items must comply with DEA instructions.

b. The HCA commanders may designate a minimum number of essential personnel within the IMSA/MEDLOG Bn/USAMMCE or pharmacy, as authorized to sign exempt certificates for the purchase of controlled substances for official use.

(1) These designated individuals must be registered with the nearest DEA regional office by completing DEA Form 225 DEA Application Form. After registration, the DEA will furnish exempt officials the needed order forms (DEA Form 222, U.S. Official Order Form Schedules I and II) and instructions. Store order forms in a locked container. Each certificate must be renewed every 3 years.

(2) When a registered individual is replaced, the HCA will forward the registration and any unused order blanks to

DEA
ATTN: Registration
600 Army Navy Dr., 6th Floor-ODOC
Arlington VA 22202

(3) The OCONUS activities may submit requests to DSCP for their assistance in procuring controlled items.

3-50. SHIPMENT OF CONTROLLED MEDICAL ITEMS

a. The custodian of controlled medical items will select and prepare the controlled items for shipment. Items will be held in secure facilities until transferred to a carrier.

b. Separate shipping documents and packing lists will cover the shipments. Both should clearly indicate quantities shipped. For individual controlled substances, the shipping documents and packing lists should indicate "medical supplies." Obliterate all markings from external containers and remark with the term "medical supplies."

c. Ship controlled medical items by registered parcel post (request return receipt) when securely packed for safe transit. All shipments must comply with weight and size limitations of the U.S. Postal Service.

d. A customs declaration tag is not required for shipments that have been addressed to a military organization by title (for example, Commander or Supply Officer) at U.S. military Post Offices OCONUS.

e. If controlled medical items cannot be shipped by parcel post because of weight or size restrictions, refer to AR 55-355/NAVSUPINST 4600.70/ AFR 75-2 /MCO P4600.14B/DLAR 4500.3.

f. Shipping documents for controlled medical items sent to or from any OCONUS destination will be marked
"SPECIAL CARGO-PLACE IN CUSTODY OF CARGO SECURITY OFFICER."

3-51. STORAGE AND ISSUE OF INSTALLATION STOCKS OF CONTROLLED MEDICAL ITEMS

a. Physical security: Storage facilities will follow the physical security standards in AR 190-51 for controlled medical items, other medically sensitive items, and all other items.

(1) Store stocks of controlled medical items in a security storage device commensurate with the type and quantity of materiel. The IMSA/MEDLOG Bns/USAMMCE's Accountable Officer will request the local Provost Marshal to survey and document the adequacy of the security per AR 190-51.

(2) Safeguard note "R" controlled medical items at each storage location. As a minimum, the security storage device should be a vault of substantial construction with a steel door and combination or key lock. Where small quantities permit, use a safe or steel cabinet (GSA Class 5 or equivalent). If the safe or cabinet weighs less than 750 pounds, attach it to a permanent structure to prevent easy removal. New vault construction will meet the DEA's minimum-security standards of non-practitioner handling of Schedule I and II controlled medical items. Existing storage vaults should also include the following:

(a) An electronic alarm system, which, upon unauthorized entry, transmits a signal directly to the appropriate military or civilian law enforcement agency.

(b) A self-closing and self-locking device to be used during normal hours when the vault door is open (frequently called a "day gate").

(3) Store note "Q" controlled medical items in safes or vaults. Where space limitations preclude, store items in a locked cage or secure room that has

limited access. New construction of cage storage areas will meet the DEA's security standards. Existing cage storage areas should also include the additional features listed above.

(4) Ethyl alcohol is classified as a Code "R" item. **The guidelines established in this SB for bulk storage of ethyl alcohol take precedence over AR 190-51 and AR 40-3 until either is superseded.** Store ethyl alcohol in a flameproof container/cabinet or storage area that meets National Fire Protection Association (NFPA) and Occupational Safety and Health Administration (OSHA) standards for storage of a flammable product. To the maximum extent practical, meet the standards in AR 190-51 for the storage of Code "R" items. However, NFPA and OSHA fire protection standards will take precedence over security requirements. As a minimum, keep the container/cabinet locked or in a secure storage area that has a limited access.

b. Managing controlled medical items.

(1) The HCA Commanders or Command Surgeons will appoint the MSO and at least one alternate to serve as the custodian of the activities' stocks of controlled medical items. The custodians/alternates will:

(a) Post all gain and loss transactions on a DA Form 1296 (Stock Accounting Record) for both stocked and nonstocked items.

(b) Maintain current security container designations and records, to include SF 700 (Security Container Information), SF 702 (Security Container Check sheet), and reversible "OPEN-CLOSED" signs per AR 380-5.

(c) Maintain a record of receipts, issues, and stock balances on DA Form 1296 at the storage site. These records are in addition to the accountable stock records that are maintained by the appropriate materiel manager.

(d) Sign for registered mail, parcels, and expressed packages addressed to the IMSA/MEDLOG Bn/USAMMCE.

(e) Issue controlled medical items directly to an authorized recipient, preferably at the security storage site. The custodian must obtain a full signature of the recipient.

(f) Complete the stock record accounting at the storage site immediately after a transaction.

(g) Retain accountable records and supporting documents for 3 years after the date of the last transaction.

(h) Authorize all issues by editing the requisitions before issue.

(i) Analyze the transactions once each month.

(j) Investigate shortages and unusual requisitions or expenditures immediately; consult with supported activities when necessary; and take corrective action if needed.

(2) The MSO will restrict the issue of all controlled medical items by:

(a) Issuing DEA-designated controlled medical items to the HCA pharmacies for dispersal to patients, wards, clinics, and other areas of the hospital. Hospitals must maintain records of these items per AR 40-2.

(b) Issuing DEA-designed controlled medical items to other activities only when authorized by the HCA commander or Command Surgeon.

(c) Issuing tax-free alcohol to hospital pharmacy and laboratory activities and other activities authorized by the commander.

(d) Issuing precious metal, PMBS, and chrome-based metals for dental use to the precious metals coordinators of supported Dental Activities (DENTAC). The coordinator is the only one who can turn in precious metals, PMBS, and chrome-based metals.

(e) Issuing instructions containing precious metals to supported activities authorized such items.

(f) Issuing controlled medical items to authorized Active and Reserve Component MTOE units with written approval from the unit commander.

(3) The local Provost Marshal will complete a local files check on vault custodians/alternates, warehouse personnel, and other personnel having access to controlled medical items or medically sensitive items per AR 190-51.

3-52. PERIODIC INVENTORIES OF CONTROLLED MEDICAL ITEMS

a. The HCA Commander or Command Surgeon will:

(1) Change disinterested inventory officer assignments each month.
(2) Provide written inventory procedures based on current Army regulations.

b. The aviation life support equipment technician will inventory controlled medical items in aviation survival kits when the periodic inspection of the complete kit is completed.

c. The Dental Command and all activities will conduct an inventory of precious metals annually to coincide with the annual quality assurance statement.

d. The inventories and corrective action consist of the following:

(1) Agreement between all stock balances on accountable records at storage locations and the quantities on-hand and the accountable stock record. If these do not agree, they must be reconciled.

(2) Authentication of the balance on stock accounting records at storage locations for each line item inventoried. The inventory officer will:

(a) Make a separate line entry on DA Form 1296 to include the date, abbreviation "INV", quantity on hand, and legible payroll signature.

(b) Submit a report of the inventory to the HCA Commander or Command Surgeon and provide a copy to the IMSA/MEDLOG Bn/USAMMCE.

(3) Corrective actions to clear all discrepancies before the next inventory. The HCA Commander or Command Surgeon will report all irreconcilable shortages immediately to the local Provost Marshal for investigation to establish a basis for subsequent action.

3-53. OTHER ITEMS REQUIRING CONTROL

a. The MSO will keep a record of controlled medical items on a DA Form 3862 (Controlled Substances Stock Record). Units with a resupply mission will use DA Form 1296. A disinterested officer, appointed by the commander, will inventory and inspect the items monthly.

b. Where unit storage security is inadequate and operational and readiness is not unduly compromised, store controlled medical item components at the lowest supply level having adequate storage facilities. The supporting IMSA/MEDLOG Bn/USAMMCE may also store these items; however, using unit personnel will inventory the stocks monthly.

(1) When stored at an IMSA/MEDLOG Bn/USAMMCE, commingled with IMSA/MEDLOG Bn/USAMMCE stocks, controlled medical item components are:

(a) Considered contingency stocks
(b) Assigned a unique project code, if applicable to automated systems
(c) Inventoried by the IMSA/MEDLOG Bn/USAMMCE

(2) When stored at an IMSA/MEDLOG Bn/USAMMCE in a container secured by the owning unit, the owning unit will inventory and survey the items.

(3) A Memorandum of Agreement (MOA) between the MTOE medical unit and the IMSA/MEDLOG Bn/USAMMCE will be established to ensure issue procedures of stored controlled medical item components are available when required for mission accomplishment.

3-54. REGULATED MEDICAL ITEMS

a. Medical materiel is a regulated medical item when one or more of the following conditions apply:

(1) The item affects the readiness of MTOE units.
(2) A centrally DA-managed funding program funds the item.
(3) Distribution and redistribution is controlled due to:
(a) Critical supply availability
(b) Unique physical properties of the item and/or its specialized use

b. For management and requisition processing purposes, identify regulated medical items as one of the following types:

(1) Procurement appropriation-funded medical equipment for MTOE units
(2) Medical Assemblages (see SB 8-75 series)
(3) Other specialized medical items whose distribution is centrally managed and controlled.

c. The AMDF or FEDLOG identifies regulated medical items as AAC "A".

d. Certain medical items may receive a temporary regulated medical item designation due to special distribution requirements. The USAMMA messages will announce the temporary regulated medical item status. These messages are available on the USAMMA website at:

e. Basic requisitioning procedures for all regulated medical items are as follows:

(1) Prepare requisitions per AR 725-50. Each year one issue of the SB 8-75 series will also describe the prescribed military standard requisitioning and issue procedures format. This issue will also contain any current, updated information on requisitioning procedures.

(2) Use "AOE" or "A05" as the DIC for all requisitions.

(3) Use "B69" as the routing identifier code for all requisitions to the USAMMA.

(4) Use the requesting unit's DODAAC in the requisition document number. If the supporting automated system requires the DODAAC be used in the document number, then identify the requesting unit in the supplementary address field.

(5) Place the original requester's complete document number and the in-the-clear name of the unit in the exception data accompanying the requisition.

(6) Transmit the requisition to the USAMMA by message with an information copy to the appropriate MACOM. Mail may be used as an alternative submission method. Do not submit requests for regulated medical items through the DAAS.

(7) Requisitions for Medical, Nuclear, Biological, Chemical Defense Materiel (MNBCDM) (Mark I Kits, ATNAA, Atropine, 2-PAM, Doxy BT of 30s, Cipro pkg of 30s, and PBT) needs the following exception data:

(a) Unit's Identification Code (UIC); and
(b) Reason for the order (i.e. Individual Service Member initial issue requirement for deployment, component of MES - need LIN of the set and quantity on-hand, other missions). Please refer to SB 8-75-S7, chapter 6, dated 20 July 2002.

f. Special requisition procedures are as follows:

(1) Submit requisitions for Other Procurement, Army (OPA) funded MTOE equipment as follows:

(a) Enter code "GA" as the fund code.

(b) Enter a type requirement code (see AR 725-50).

(c) Identify the MES that the regulated medical item is a component of or related to in the exception data accompanying the requisition (for example, MES that comprises a unit's primary equipment authorization).

(d) Format and transmit ARNG requisitions per the SB 8-75 series (SB 8-75-S10).

(2) Submit requisitions for MESs as follows:

(a) If funded by the requester, the requester will commit the appropriate OMA funds with stock fund code obligation from the requisitioner (for example, SSA).

(b) Enter a type requirement code (see AR 725-50).

(c) Include the following statement as exception data to USAR and ARNG requisitions: "Unit is authorized MESs by MTOE (provide MTOE number) and has capability to store and maintain the MESs."

(d) Include the current authorization, Unit Identification Code (UIC), and reason for shortage, initial issue, or replacement as exception data with each requisition.

(3) Requisition other regulated medical items as follows:

(a) The requester will fund the items if a USAMMA message identifies the item for a special or centrally funded program.

(b) The USAMMA will identify special exception data in a message series.

g. Requisitions for MNBCDM requires exception data as listed in SB 8-75-S7 chapter 6. To route requisitions for regulated medical items (AAC "A"), follow these procedures:

(1) For CONUS and OCONUS active duty units:

(a) The requester submits requisitions to the supporting IMSA/MEDLOG Bn/USAMMCE.

(b) The IMSA/MEDLOG Bn/USAMMCE sends the requisition to the USAMMA with an information copy to the requester's MACOM.

(c) The USAMMA validates the requirement with the appropriate MACOM as required.

(2) For USAR units:

(a) The requester submits a requisition through normal channels, in accordance with local procedures, to their MSC.

(b) The MSC validates the requirement and assigns funds for OMA Reserve-funded items.

(c) The MSC forwards the requisitions to the supporting IMSA/MEDLOG Bn/USAMMCE.

(d) The IMSA/MEDLOG Bn/USAMMCE sends the requisition to the USAMMA for validation.

(3) For ARNG units:

(a) The requester submits a requisition to the USPFO.

(b) The USPFO assigns funds for operations and maintenance, NG-funded items and forwards the requisition with a transmittal letter through

Chief, National Guard Bureau
ATTN: NGB-ARS
111 South George Mason Drive
Arlington VA 22204-1382

to

Commander, USAMMA
ATTN: MCMR-MMB-R
1423 Sultan Drive, Suite 100
Fort Detrick MD 21702-5001

h. The USAMMA procures and issues all regulated medical items.

i. The supplier will provide the shipping status to the USAMMA and requesting unit per AR 725-50. Requesting units should submit follow-ups to the USAMMA.

3-55. MEDICAL EQUIPMENT AND PROVISIONED ITEMS

a. Medical equipment end items purchased for field use and requiring unique support and maintenance will be procured with the following provisioned items.

(1) Transportation/carrying case
(2) Accessories and consumables required for item to be functional when received (3-day start-up kit)

(3) Operator and maintenance manuals (1 Hard Copy, 1 Electronic Copy)
(4) Spare parts List
(5) Repair parts List
(6) Training material, to include Operator & Maintenance materials
(7) Consumables and accessories item list
(8) Calibration and diagnostic equipment list
(9) Identification of special tools required for repair/calibration/operation

b. Medical equipment and provisioned items will be assigned a generic NSN with AAC "W". The AAC "W" NSN is used for procurement of the equipment items. The items to support and maintain the make/model specific medical equipment and provisioned items will be requisitioned using an AAC of "J", "D", "A", or "L."

c. Medical equipment and provisioned items can be either OPA or Operations and Maintenance, Army (OMA) funded as determined by the appropriation and budget activity account code of the MCSC in the AMDF or FEDLOG.

d. The USAMMA will centrally fund all new components, both OPA and OMA, identified to a Unit Assemblage (UA) for Units being sustained. All other Units are to keep their sets maintained to the 1999 update. If a Unit Commander determines they are procuring the updates, notification to the USAMMA is requested.

e. The USAMMA messages will announce provisioned medical items, which are available on the USAMMA website.

f. Basic requisitioning procedures for all procurement appropriation provisioned medical equipment items are as follows:

(1) Prepare standard MILSTRIP requisitions per AR 725-50.

(2) Forward requisitions through appropriate Class VIII supply channels to the USAMMA for funding and requirement validation review.

(3) Use "AOE" or "AO5" as the DIC for all requisitions.

(4) Use "B69" as the RIC for all requisitions for AAC "W" end items to the USAMMA.

(5) Include a valid sole source justification with requisitions for AAC "J" NSNs. If not included, the requisition will be canceled and returned to the requesting unit.

(6) Use the requesting Unit's DODAAC in the requisition's document number. If the supporting automated system requires the SSA's DODAAC in the document number, then identify the requesting unit in the supplementary address field. All requisitions will contain the original requester's complete document number and the in-the-clear name of the unit, i.e., 228th Combat Support Hospital (CSH), in the EXCEPTION DATA accompanying the requisition.

(7) Submit the requisition to the USAMMA by message with an information copy to the appropriate MACOM. Mail may be used as an alternative submission method. Do not submit requests for Procurement Appropriations (PA) provisioned medical equipment items through the DAAS.

(8) Include the following information in the exception data for each requisition. The requesting unit must furnish this information.

(a) Current authorization (MTOE and effective date)
(b) UIC
(c) Reason for shortage (that is, initial issue or replacement)

g. The USAMMA will forward all validated and funded requisitions to the DSCP.

h. The DSCP will:

(1) Convert the requester's AAC "W" NSN to a specific AAC "J" NSN provisioned item for subsequent processing and issue to the requester.

(2) Assign a specific NSN to each different manufacturer make and model item that meets the generic essential characteristics of the NSN AAC "W" item.

3-56. REFERENCE BOOK SETS FOR MEDICAL MTOE UNITS

a. The MTOE and other Army authorization documents authorize the book sets for MTOE units. The Army Medical Department Center & School (AMEDDC&S) will:

(1) Determine the components of book sets
(2) Review book sets annually
(3) Publish through the USAMMA and USAPA, the revised component listings in the SB 8-75-S9 series

b. To obtain individual books for book sets:

(1) Use local purchase procedures (see instructions in SB 8-75-S9 dated 20 September 2002)
(2) Use current general services, administration FSS, and FSG 76

3-57. REVIEW PROGRAM FOR DURABLE MEDICAL MATERIEL

a. The HCA Commanders/Command Surgeons establish a formal program for reviewing the consumption of durable medical materiel. This program is designed to:

(1) Improve supply discipline
(2) Emphasize economy
(3) Monitor usage
(4) Focus attention on the prudent use of durable medical materiel

b. To manage the program, commanders conduct semi-annual consumption reviews. The review should include the 20 durable medical materiel items where the activity experienced the greatest expenditure during the last year. During the semi-annual review, Commanders should focus attention on increased usage and potential savings for the activity. Reviews may also be conducted on the remaining durable

medical materiel items for which the activity desires control visibility, such as items experiencing a high loss rate. From this review, items will be selected for intensive management and will be managed as stated below (see para c and d). The ARNG activities will conduct annual reviews.

c. Durable medical materiel selected for intensive management may be managed as turn-in and direct exchange items. If an unserviceable item is not available for exchange, a letter or form can be required by the IMSA/MEDLOG Bn/USAMMCE justifying the items.

d. Usage levels can be established for the organization and for individual customers. Actual usage should be reviewed against established usage levels. Activities will document the review to include corrective action taken or the cause(s) for usage in excess of the established rate. These reviews will be maintained according to AR 25-400-2.

e. The MTOE units normally will not establish usage levels unless actively engaged in patient care.

f. Activities will dispose of uneconomically repairable durable medical materiel items through their IMSA/MEDLOG Bn/USAMMCE to the DRMO.

3-58. CONTROLLING NEEDLES AND SYRINGES

The HCA activities will maintain adequate control of needles to prevent misuse or access by unauthorized persons. The storage and security of needles are outlined in AR 190-51. Disposable syringes that do not have needles are exempt from this requirement.

3-59. RADIOACTIVE MATERIEL

a. Commanders of HCAs using radioactive materiel will designate, in writing, a radiation safety officer (See AR 40-14/DLAR 1000.28 and TB MED 525). This officer will:

(1) Control, receive, issue, use, store, and dispose of radioactive materiel.

(2) Comply with Nuclear Regulatory Commission licenses and Army authorizations.

(3) Advise local fire authorities of the type, quantity, and locations of concentrations of radioactive materiel that may pose a hazard in an emergency.

b. The HCA will acquire and control radioactive materiel per TB MED 525, AR 385-11, 10 CFR, and the conditions of the activity's NRC license or Department of the Army Radiation Authorization (DARA).

3-60. SOURCES OF DEFENSE ATTACHÉ MEDICAL SUPPLY SUPPORT

a. Army personnel serving, as Defense Attachés will use local supply sources or HCA located within a reasonable distance.

b. Major OCONUS Commanders will provide medical supply support upon request if:

(1) The personnel are stationed within the command's area of support.

(2) Communications and transportation permit: Examples of communication and transportation that may be available are State Department pouch, U.S. Military Post Office, or Embassy Post Office.

c. Commander, WRAMC:

(1) Provides medical supply support where other sources are not available or where difficulties exist in communications.

(2) Designates the U.S Army Health Clinic, Pentagon, as a supply source. Forward requests for medical supplies through the Army's Assistant Chief of Staff for Intelligence to the U.S. Army Health Clinic, Pentagon. Normally, this supply action is limited to delivery by State Department pouch.

d. Prescription-type items will be dispensed from a pharmacy when a doctor's prescription is presented, per AR 40-2.

e. Requests for exception to this procedure will be forwarded to USAMEDCOM, ATTN: MCLO-O.

3-61. FINANCING MEDICAL SUPPLIES FOR ATTACHÉS

Medical funds available to the command will finance medical supplies issued pursuant to this section unless different billing arrangements have been made.

3-62. MEDICAL MATERIEL MANAGEMENT PROCEDURES BY RESERVE COMPONENT AND ARNG PERSONNEL THAT ARE ASSIGNED A PATIENT-CARE MISSION

a. The USAR and ARNG units may requisition and use controlled, shelf life refrigerated materiel when they provide patient care to military personnel authorized such care by AR 40-3. During use, ARNG and USAR units will control and account for those items according to this chapter and AR 40-2. The ARNG units will also comply with pharmaceutical management procedures in the SB 8-75 series.

b. When the patient-care mission has been completed:

(1) The USAR units will coordinate the turn-in of all unused stocks to the supporting IMSA/MEDLOG Bn/USAMMCE.

(2) The ARNG units will:

(a) Return all controlled items per para 3-50.

(b) Return as directed by the USPFO unit of issue quantities of all other items unlikely to be consumed prior to their expiration date. Return these items within 60 days of the completion of the patient care mission.

(c) Return FSC 6505 items that are on the IMSA/MEDLOG Bn/ USAMMCE stockage list and unlikely to be consumed within 12 months.

(d) Manage remaining stocks as specified in applicable regulations and the SB 8-75 series.

(e) Report all on-hand medical MNBCDM to

Commander, USAMMA
ATTN: MCMR-MMB-R
1423 Sultan Drive, Suite 100
Fort Detrick MD 21702-5001

3-63. MEASURING MEDICAL SUPPLY PERFORMANCE

This chapter provides formulas for computing medical supply performance standards (in addition to those outlined in AR 710-2).

3-64. MEASURING CUSTOMER SUPPORT

a. Demand satisfaction: Demand satisfaction represents the percentage of demands for stocked lines satisfied by 100 percent of the total quantity demanded. Used the formula shown below to compute this figure:

b. Formula:

$$\frac{\text{Valid Demands for Stocked Items 100\% Filled}}{\text{Total Valid Demands for Stocked Items Received}} \times 100 = \text{Demand Satisfaction Stocked Items Satisfied by 100\%}$$

c. Example: 6,378 of 6,700 total demands for stocked items were 100 percent filled.

$$\frac{6{,}378}{6{,}700} \times 100 = 95\%$$

d. Performance measures are as follows:

(1) Management objective: 95 percent
(2) Management level 90 to 98 percent

e. Indicates the adequacy of RO levels; that is, whether stockage quantities are sufficient considering OST and fluctuating demands.

f. May indicate, if extremely high, that stock levels are too high. If demand satisfaction is low, examine the:

(1) Zero-balance rate
(2) Receipt processing time
(3) Validity of OST quantities based on recent experience

3-65. MEASURING PROCESSING TIME

a. Request processing time:

(1) For stocked lines, it is the number of days from the date a customer request is received at the IMSA/USAMMCE/MEDLOG Bn to the date the materiel is delivered to the customer or the customer is notified that the materiel is ready for pickup.

(2) For nonstocked lines, it is the number of days from the date a customer request is received at the IMSA/USAMMCE/MEDLOG Bn to the date the request is passed to the supply source or to the supporting contracting activity.

(a) To compute the request processing time at the IMSA/USAMMCE/ MEDLOG Bn, survey past customer requests. The date received is not counted; however, the date passed to the supply source or supporting contracting activity is counted, as is the date of delivery or date of notification to the customer.

(b) This measure indicates the efficiency of the IMSA/USAMMCE/ MEDLOG Bn in processing requests for both stocked and nonstocked lines. Longer processing times may indicate:

(1) System deficiencies
(2) Inadequate staffing
(3) Training shortfalls
(4) A combination of these factors

(3) Performance measures are as follows:

(a) Management objective: 1 day
(b) Management level: 1 to 2 days

b. Receipt processing time:

(1) This measure represents the lapsed time from the receipt of materiel at the IMSA until the receipt is posted to accountable records.

(2) Use the receipt documentation and accounting records to obtain needed information. The date received is not counted; however, the date posted is counted.

(3) Performance measures are as follows:

(a) Management objective: 1 day
(b) Management level: 1 to 2 days

(4) Longer processing times may indicate:

(a) Inadequate receiving or posting procedures
(b) Training needs
(c) Staffing level problems

3-66. MEASURING INVENTORY MANAGEMENT

a. Zero balance rate (percentage out of stock).

(1) The zero balance rate indicates the percentage of stocked lines that are at zero balance.

- It is an indicator of inventory management effectiveness and is usually related to demand satisfaction.
- It's a measurement that detects inventory management problems earlier than other indicators.
- It gives a rapid general picture of inventory status for RO/level (demand supported) stocked lines at a given point in time.

Potential problems highlighted by this indicator may not have been discovered with other indicators, because the system deficiency may have occurred only recently. For example, if a series of requisitions to a supply source had been lost or if transportation breakdowns had frustrated one or more shipments, this measure would quickly reflect either problem. Only later would these same problems also affect the demand satisfaction. A very low zero balance rate may reflect significant improvements in the resupply system, improvements in transportation support to the IMSA, or a significant downturn in customer demands.

(2) Formula:

$$\frac{\text{Number of Stocked Lines at Zero Balance with an Established Due - Out}}{\text{Number of Stocked Lines}} \times 100 = \text{Zero Balance Rate}$$

(3) Example: If there are 70 stocked lines at zero balance out of a total of 1,578 stocked lines, then:

$$\frac{70}{1{,}578} \times 100 = 4\%$$

(4) Performance measures are as follows:

(a) Management objective: less than 5 percent
(b) Management level: 2 to 8 percent

b. Issue priority designator (IPD) high priority request/requisition rates.

(1) This rate indicate the percentage of all requisitions placed upon a supply source (either local procurement or the DLA supply system) that have an IPD of 01-08 (exclude life or death IPD 03 requisitions from all calculations).

(2) Use the formula below for computing these rates.

(a) Formula:

$$\frac{\text{IPD 01 to 08 Requests/Requisitions}}{\text{Total Requests or Requisitions}} \times 100 = \text{IPD Request/Requisition Rate}$$

(b) Example: If there are 17 Issue Priority Designator (IPD) 01 through 08 requests/requisitions out of 189 total requests or requisitions submitted,

$$\frac{17}{189} \times 100 = 9\%$$

(3) Performance measures are as follows:

(a) Management objective: Less than 20 percent
(b) Management level: None

(4) Excessive use of high IPDs is symptomatic of a variety of potential problems but may, infrequently, be totally reasonable and necessary. Routine use of IPDs 01 through 08 indicates the following:

(a) Basic data believed reliable in establishing OST values may not be valid.
(b) Proper materiel is not stocked.
(c) Customers require assistance in identifying new requirements for IMSA/MEDLOG Bn/USAMMCE stockage or need assistance in establishing a local resupply mechanism.
(d) The pipeline for heavily demanded materiel has been interrupted.
(e) A new, high priority mission is demanding expedited support.

c. Inventory accuracy rate

(1) The inventory accuracy rate provides information regarding the accuracy of on-hand balances recorded on accountable records.

(a) Formula:

$$\frac{\text{Total Number of Lines Requiring Adjustment}}{\text{Total Number of Lines Inventoried}} \times 100 = \text{Percentage}$$

Then,

$$Percentage \quad - \ 100\% = \text{Inventory Accuracy Rate}$$

(b) Example: If 100 lines required adjustment at the conclusion of the inventory and 1,000 lines were counted,

$$\frac{100}{1{,}000} \times 100 = 10\%$$

Then,

$$100\% - 10\% = 90\%$$

The inventory accuracy rate is 90 percent.

(2) Performance measures are as follows:

(a) Management objective: 95 percent
(b) Management level: 90 percent or above

(3) Values less than 90 percent indicate a problem as to the reliability of on-hand balances. Problems affecting accuracy may be failure to post receipts in a timely manner or issuing items by the wrong unit of issue.

d. Percent of excess to total inventory.

(1) Excess inventory is that materiel measures both the stocked and non-stocked inventory that is not supported by demands.

(a) Formula:

$$\frac{\text{Dollar Value of Excess Inventory}}{\text{Dollar Value of On - Hand Inventory}} \times 100 = \text{Percent of Excess to Total Inventory}$$

(b) Example: The account has $25,000 of excess (stocked and non-stocked combined) as shown in the Stock Status Report. Total dollar value of on-hand inventory is $1,000,000. The percent of excess to total inventory would be:

$$\frac{\$25{,}000}{\$1{,}000{,}000} = 0.025 \times 100 = 2.5\%$$

(2) Performance measures are as follows:
(a) Management objective: 10 percent or less.
(b) Management level: not greater than 15 percent

(3) A rate greater than 15 percent indicates that the account is not taking timely action to remove non-demand supported items from the inventory.

e. Maximum percent of IMSA/MEDLOG Bn pharmaceutical stockage levels (CONUS activities only).

(1) This measures the percent of pharmaceutical stocks to the value of annual pharmaceutical orders. The intent is to maximize utilization of government contracted commercial distributors (PV). Utilizing these contracts results in inventory reduction through engaging "Just in Time" supply support.

(a) Formula:

$$\frac{\text{Dollar Value of Pharmaceutical Stockage Level}}{\text{Annual Total Dollar Value of Pharmaceuticals Ordered}} \times 100 = \text{Max \% of Pharmaceutical Stockage Levels}$$

(b) Example: The IMSA/MEDLOG Bn has a stockage level for pharmaceuticals valued at $50,000. During the year, the pharmacy service ordered $5,000,000 of pharmaceuticals directly from a government contracted commercial distributor. The percent of IMSA/MEDLOG Bn pharmaceutical stockage level would be:

$$\frac{\$50{,}000}{\$5{,}000{,}000} = 0.01 \times 100 = 1\%$$

(2) Performance measures are as follows:
(a) Management objective: Less than 4 percent
(b) Management level: None

(3) A rate of 4 percent or greater may indicate that the IMSA/MEDLOG Bn is investing too many dollars in pharmaceutical inventory. In this case the IMSA/MEDLOG Bn is not taking advantage of PV contracts as a means of reducing inventory.

3-67. MEASURES OF STORAGE MANAGEMENT

a. Materiel release denial rate (warehouse denials)

(1) This rate is the percentage of materiel release orders (MRO)/pick list denied by storage. It indicates the number of MROs/pick list lines generated where stock is not on-hand in the warehouse, though records indicate that on-hand balances exist.

(a) Formula:

$$\frac{\text{Number of MRO Denials}}{\text{Total MROs}} \times 100 = \text{Materiel Release Denial Rate}$$

(b) Example: If there are 28 MRO/pick list denials out of 3,253 total MROs/pick list lines, then:

$$\frac{28}{3{,}253} \times 100 = 0.9\%$$

(2) Performance measures are as follows:

(a) Management objective: 1 percent
(b) Management level: 0-2 percent

(3) This measure can indicate a variety of potential problems, such as:

(a) Erroneous inventories
(b) Locator inaccuracies
(c) Stocks released to customers without the transaction being posted to accountable records
(d) Inaccurate selection of materiel for shipment or delivery
(e) Erroneous quantities verified on receipt documents
(f) Erroneous posting of receipt documents or misappropriation

b. Location accuracy (see AR 710-2)

(1) This measure is a comparison of locator records with actual physical location of assets expressed as a percentage of accuracy. It is produced from a random sample of storage locations from either the locator records or from the physical location.

(2) There are two types of location survey errors:

(a) Location records showing a recorded location without corresponding stock at that warehouse location, provided that a permanent location is not being reserved for the item.

(b) Physical assets in warehouse locations without a supporting location record.

(3) Formula

$$\frac{\text{Total Correct Inventory Locations}}{\text{Total Inventory Locations Surveyed}} \times 100 = \text{Location Accuracy}$$

(4) Example: If out of 150 locations surveyed, 146 were correct, then:

$$\frac{146}{150} \times 100 = 97\%$$

(5) Performance measures are as follows:

(a) Management objective: 98 percent
(b) Management level: Greater than 95 percent

(6) Location accuracy shows the effectiveness of the storage activity at placing materiel in its designated location and posting appropriate data to locator records, to include deleting invalid location assignments resulting from rewarehousing and stock depletion.

CHAPTER 4. QUALITY CONTROL

4-1. SOURCES OF QUALITY CONTROL INFORMATION

a. The Army Quality Control Information is disseminated in three ways:
- Department of Defense Medical Materiel Quality Control (DoD-MMQC) Messages;
- DOD Shelf Life Extension Program (DOD-SLEP) Messages; and / or
- Army Medical Materiel Information (MMI) Messages.

(1) Procedures: Supply accounts at the IMSA/MSA/MEDLOG Bn/USAMMCE level will maintain a record, either automated or manual, of these messages in numerical sequence. As a minimum, the data will reflect the date received, message number, NSN (or other identifying number), nomenclature, action required, and remarks. If a message is missing, initiate tracer action through message routing channels or obtain a copy from:

(a) World Wide Web address:
http://www.armymedicine.army.mil/usamma

(b) Commander, USAMMA
ATTN: MCMR-MMB-R
1423 Sultan Dr., Suite 100
Fort Detrick MD 21702-5001

(c) Activities with an automated QC module in their inventory management system, i.e., TAMMIS/DMLSS, are not required to maintain a manual register. The MMQC messages will be retained on file for at least the current calendar year and the prior calendar year per AR 25-400-2.

(2) Transmission:
- The DoD MMQC and DoD SLEP messages are transceived worldwide to units and activities of the Active Army, USAR, and ARNG, as well as the other services.
- The USAMMA Medical Materiel Information (MMI) messages are transceived worldwide to units and activities of the Active Army, USAR, and ARNG only.

(3) Address indicator group (AIG): The current composition of each AIG under which messages are dispatched is published annually in SB 8-75-S3. Requests for AIG additions, deletions, or modifications will be submitted to:

Commander, USAMMA
ATTN: MCMR-MMB-R
1423 Sultan Dr., Suite 100
Fort Detrick MD 21702-5001

Beginning approximately September 2000, the Defense Messaging System (DMS) began replacing the Autodin method of message transmission. The USAMMA is presently maintaining both AIG and DMS capability. The USAMMA will maintain "Mailing lists" for message dissemination via DMS electronic mail that will comprise essentially the same addressees as the former AIGs. DMS addresses must be

obtained from individual activity Director of Information Management (DOIM) offices or points of message traffic receipt. Initial contact will be made to the USAMMA (MCMR-MMB-R) reporting assigned DMS addresses to assure uninterrupted receipt of the USAMMA QC messages. As with AIGs, requests for deletions or modifications to DMS mailing lists will be submitted to:

Commander, USAMMA
ATTN: MCMR-MMB-R
1423 Sultan Dr., Suite 100
Fort Detrick MD 21702-5001

(4) The IMSA/MSA/MEDLOG Bn/USAMMCE are responsible for making distribution of QC messages to support customers.

(5) Army National Guard actions: Upon receipt, Chief, National Guard Bureau will distribute copies of all MMQC messages to DMSO and ARNG training sites operating troop medical clinics. Additionally, the Chief, National Guard Bureau, will immediately distribute all MMQC messages concerning Type I medical materiel complaints and the Food and Drug Administration (FDA) Class I recalls to the State Safety Office and all medical elements in the State, including separate medical detachments and medical sections of maneuver battalions.

(6) The USAR action: The MEDLOG Bns and U.S. Army Reserve Command's (USARC) medical units designated as a SSA within a command or area of operations are responsible for the distribution of all applicable DoD MMQC messages to supported customers.

b. On-line query search: The USAMMA has an on-line query capability for all QC messages and information bulletins. Search by Message MMQC/SLEP/MMI Number, National Stock Number (NSN), National Drug Code (NDC), Subject, or Lot Number by accessing the USAMMA homepage at **http://www.armymedicine.army.mil/usamma.**

c. The SB 8-75 series: The SBs are distributed through normal Army distribution channels and provide other essential medical logistical information.

d. The AR 702-18/DLAR 4155.37/AFR 67-43: This publication contains storage QC procedures and serviceability standards applicable at all levels of materiel management. Questions related to information contained in the publications may be directed to:

Commander, USAMMA
ATTN: MCMR-MMB-R
1423 Sultan Dr., Suite 100
Fort Detrick MD 21702-5001

e. The AMDF or Federal Logistics Data on Compact Disc (FEDLOG), UDR, and DLIS: The AMDF or FEDLOG, UDR, and DLIS are the official sources of supply management data, i.e., shelf life codes (SLCs). They have precedence over conflicting data published in other Army publications and AR 702-18/ DLAR 4155.37/AFR 67-43, unless otherwise stated in DoD QC messages.

f. Commercial recall notices: The IMSA/MSA/MEDLOG Bn/USAMMCE will ensure that all statements of work for commercial source acquisition will include the requirements for recall notices to be sent electronically to the original ordering activity. The IMSA/MSA/MEDLOG Bn/USAMMCE will be responsible for ensuring that the information contained in these recall notices is disseminated to all customers unless otherwise stated in DoD MMQC or MMI messages.

4-2. MEDICAL MATERIEL STORAGE PROCEDURES AND SHELF LIFE OF MEDICAL MATERIEL

a. Storage conditions: Specialized procedures and equipment are required to prevent the deterioration of medical materiel in storage. Medical materiel is frequently sensitive to sunlight, heat, and moisture. Therefore,

(1) Emergency or battery powered temperature alarm systems will be used on refrigerator storage units at the IMSA/MSA/MEDLOG Bn/USAMMCE. Alarms will be electrically monitored on a 24-hour basis. This can be done manually or through technical design. Items requiring refrigeration will be stored and shipped at temperatures between 36º and 46º Fahrenheit (F) or 2º and 8º Celsius (C) and frozen items at temperatures below 32º Fahrenheit (0º C).

(2) Heat, refrigeration and humidity control will be provided when necessary to protect medical materiel in accordance with all special instructions on the item, shipping label, manufacturer/product literature, UDR, Technical Manual (TM) 743-200-1 or in the Federal Supply Catalog (FSC).

(3) X-ray film will be stored per manufacturer's recommended storage methods, usually on edge in a vertical position. Film may fog if stored horizontally.

(4) Dry-cell batteries will be removed from instruments prior to storage.

(5) Rubber goods will be stored in rolls or laid flat. Talc will be used to separate surfaces.

(6) Controlled items that require special storage and handling procedures to protect against theft will be stored per AR 190-51, AR 40-2.

(7) Hazardous materiel, including acids, flammables, corrosives, gases, and poisons will be stored per:

(a) TM 743-200-1
(b) TM 38-410/Defense Logistics Agency Manual (DLAM) 4145.11/Navy Supply Publication (NAVSUP PUB) 573/AFR 69-9/MCO 4450.12
(c) AR 200-1
(d) Applicable Federal, state and local laws

(8) When placing medical materiel in storage, at a minimum, consider the following:

(a) Compatibility of chemicals
(b) Ventilation
(c) Fire protection

(d) Spill prevention and response
(e) Containment
(f) Protection from the weather

(9) Post an inventory list and all applicable Materiel Safety Data Sheets (MSDS) near the storage area within the activity.

(10) Suspended materiel will be physically separated from other stock and marked with the authority for suspension.

b. Storage of QC records. The IMSA/MSA/MEDLOG Bns/USAMMCE will maintain supplemental records for all expiration-dated materiel. Other medical supply operations will maintain QC records in accordance with command or command surgeon guidance. As a minimum, QC records will reflect the manufacturer, lot number, and current expiration date. The DA Form 4996-R (Quality Control Card) or automated records, i.e., TAMMIS/DMLSS QC module, will be used. The DA Form 4996-R is locally reproducible on 8X 5-inch card stock. Table 4-1 provides the preparation steps for DA Form 4996-R. Use QC records to:

(1) Ensure rotation of stocks.
(2) Prepare reports of items that cannot be used prior to expiration for extension, disposal, or destruction.
(3) Budget for replacement of expired stocks.

c. Marking Type I (excluding pharmaceuticals/drugs), Type II Extended Shelf Life Items (Monographs), and Estimated Storage Life (ESL) Items. Medical items in storage whose expiration date is being extended will be re-marked as follows:

Table 4-1. Steps to Preparing DA Form 4996-R

Step	Description
1	NSN: NSN/management control number (MCN)/universal product number/NDC (pen entry)
2	Description: Name of item (pen entry)
3	Inspection frequency: How often does this item need to be inspected? (See AR 702-18/DLAR 4155.37/AFR 67-43, UDR, or DLIS)
4	Date last inspected: (pencil entry)
5	Date next inspection: (pencil entry)
6	Manufacturer: Name of manufacturer. There may be more than one.
7	Lot number: Lot number from package.
8	Expiration date: Expiration date on package, if applicable.
9	Date manufactured: Date manufactured on package, if applicable.
10	Shelf life: Type I (excluding pharmaceuticals/drugs), Type II, and ESL from FEDLOG or UDR
11	Date received: (pencil entry)

d. Marking Potency-Extended (Type I, pharmaceuticals/drugs) Items: See DoD-SLEP Message, SLEP-MMQC-02-5037, for guidance.

4-3. QUALITY ASSURANCE FOR MEDICAL GASES

a. Bulk (liquid) gases may be oxygen or ethylene oxide. The QA procedures for bulk (liquid) gases follow:

(1) The HCA Commander will designate in writing, those individuals who must have received training in the use of the gas analyzer as being responsible for monitoring bulk gas deliveries. These individuals will:

(a) Document name of individual responsible for receipt of bulk gas and date and time of delivery.
(b) Document the results of gas analysis before acceptance.
(c) Document amount received.
(d) Document corrective actions if gas fails to meet standards (less than 95 percent by volume for oxygen).
(e) Maintain accuracy of gas analyzing equipment.

(2) The HCA Commander will ensure that the bulk gas storage container has an outlet that allows for gas analysis. Specific storage procedures for bulk gases are found in AR 700-68 and NFPA codes.

(3) Records of receipt and gas analysis must be maintained for two years per AR 25-400-2.

(4) The HCA Commander will establish a written plan to handle bulk gas emergencies (medical gas alarms or equipment failures). This plan must identify clinical areas requiring alternate gas supply until the central supply is functioning properly.

(5) Equipment using bulk gases must be tested for proper functioning before patient's use. Follow manufacturer guidelines to complete this testing.

(6) The HCA Commander must ensure that all personnel handling bulk gases are properly trained. Training must be documented.

b. Medical gases maintained in cylinders require QA procedures.

(1) Upon receipt, the cylinders containing oxygen must have DD Form 1191 (Warning Tag for Medical Oxygen Equipment) attached (TB MED 245), and cylinders containing any other gas must have the cylinder valve cap in place.

(2) Cylinders must be inspected upon receipt for proper color-coding, bulges, or damage (MIL-STD-101).

(3) Cylinders must be stored per NFPA codes and AR 700-68.

(4) Regulation is that a cylinder cannot be refilled and shipped if past retest date(s). It is okay to continue to use gas from a cylinder that is past due for retest. There is no time limit imposed. However, a cylinder cannot be refilled and shipped if past retest date(s).

(5) Safe handling practices of cylinders must be followed (TB MED 245).

(6) Disposal and turn-in procedures are contained in AR 700-68, Sections 7 and 8.

4-4. STORAGE PERIODS FOR MEDICAL MATERIEL

a. Potency-extension requests:

(1) Any activity managing and storing medical materiel that meets the above criteria may request storage period extensions by submitting a letter or message request to:

Commander, USAMMA
ATTN: MCMR-MMS-M
1423 Sultan Dr. Suite 100
FT Detrick MD 21702-5001

Submit requests not later than 180 days before the expiration date. This lead-time is needed to perform administrative and technical reviews to determine if an expiration date may be extended. On-line query and SLEP nomination capability is available on the USAMMA's web site at **http://www.armymedicine.army.mil/usamma**.

(2) Users should provide the following with each request:

(a) NSN
(b) Nomenclature
(c) Manufacturer date
(d) Contract number
(e) Lot or batch number
(f) Original expiration date
(g) Current expiration date
(h) Projected quantity on-hand at shelf life expiration
(i) Extended dollar value per lot or batch

b. Test considerations: Since the cost of testing varies with each item depending on the protocol, an activity can meet the minimum dollar criteria but have its request returned, because the cost of the test is more than the potential savings achieved through extension.

c. Submission of samples: When a potency-testing project is established, the USAMMA will advise the requesting activity to forward samples. The activity must respond quickly to ensure the timeliness of the testing process.

d. Guidance for materiel pending extension action. Items meeting the criteria in para 3-8f will be suspended for 180 days beyond their expiration date, pending notification by the USAMMA of results of the extension request. If extension instructions or other guidance from the USAMMA is not received by the 180th day, the activity should contact the USAMMA for explanation.

e. The DoD/FDA SLEP.

(1) The USAMMA will review and identify requests from medical activities for those items that meet the criteria for this program. Items to be extended under this program may be Type I only.

(2) Activities submitting asset information must exercise extreme care. The USAMMA will review and identify the items, but activities will provide specific data for on-hand assets; for example, NSN, nomenclature, manufacturer, lot numbers, quantity and manufacture expiration date. The accuracy of the data submitted to the USAMMA is essential to the success of the program. Activities will, unless otherwise advised by the USAMMA, suspend materiel upon reaching the expiration date. Under this program, activities will hold materiel in suspension until notified by the USAMMA to either extend the materiel or destroy the materiel.

(3) While only selected activities will be requested to submit asset information for the program, extensions granted by the FDA will apply to all activities that have maintained materiel under the prescribed storage conditions.

(4) The SB 8-75 series, SLEP-MMQC messages, and other USAMMA messages will provide guidance for the Army's participation in the program.

4-5. INSPECTION OF LOCALLY PURCHASED MATERIEL

a. Personnel assigned to the receiving section of the IMSA/MSA/MEDLOG Bn/USAMMCE will inspect all materiel before acceptance. When materiel is delivered direct to the activity/requester, individuals receiving materiel are required to conduct an inspection prior to acceptance. The SLEP-MMQC messages should be used for this surveillance. Furthermore, IMSA/MSA/MEDLOG Bn/USAMMCE should report any problems discovered relative to usage as medical materiel complaints. This requires a visual inspection of materiel to ensure that the product appears in good condition. For specialized materiel requiring inspection expertise beyond the capabilities of the IMSA/MSA/MEDLOG Bn/USAMMCE, the requester or other appropriate specialist should assist in the inspection. The supporting medical maintenance activity will perform technical inspections of all medical equipment as appropriate. Receiving reports will be processed in a timely manner. Report problems with materiel identified after the receiving report has been processed to the supporting contracting officer for appropriate resolution. The USAMMA can provide assistance in specialized or technical inspections.

b. The IMSA/MSA/MEDLOG Bn/USAMMCE or credit card holder will respond within the scope of their authority using local credit card procedures to resolve the issues. Contact the issuing contracting office for further resolution as required.

c. The receiving activity/requester must forward a copy of the MSDS when direct delivery occurs to the IMSA/MSA/MEDLOG Bn/USAMMCE and comply with the activity’s hazard communication program.

4-6. SURVEILLANCE OF MATERIEL

a. All activities that stock medical materiel will establish a surveillance program to provide for the scheduled inspection of medical materiel. When appropriate, activities should rotate mobilization reserve stocks with operating stocks. Timely action is necessary to preclude undue loss through deterioration or destruction.

b. The basic publications used for surveillance programs are
:

(1) AMDF or FEDLOG
(2) AR 702-18/DLAR 4155.37/AFR 60-10, Appendix M
(3) SB 8-75 series
(4) Military Item Disposition Instructions (MIDI)
(5) Universal Data Repository (UDR)
(6) Defense Logistics Information System (DLIS)
(7) Military Environmental Information Source (MEIS)
(8) DoD-MMQC messages

c. AR 702-18/DLAR 4155.37/AFR 60-10, Appendix M contains the procedures and standards for visual inspections of medical materiel. The standards identify the physical properties (discoloration, precipitation, odor change, and so forth) that would indicate product deterioration and render the item unsuitable for issue and use. The Appendix M is available for viewing on the USAMMA's web site at **http://www.armymedicine.army.mil/usamma**.

d. The following actions may result from an inspection of estimated storage life items or in a dated shelf life item:

(1) Considering items that do not show physical signs of deterioration as suitable for continued issue and use until the next inspection date, unless directed by the USAMMA.

(2) Reporting items that show signs of physical deterioration (see para 4-10). Quantities on-hand will be held pending disposition instructions from the USAMMA, the supporting commercial contracted distributor, or by command decision.

4-7. RECALL OF NONSTANDARD DRUGS AND DEVICES

a. A nonstandard drug is any item that does not have a Joint Readiness Clinical Advisory Board (JRCAB)-approved NSN. Nonstandard drugs and devices announced by the FDA as being recalled by manufacturers or distributors will be published in DoD-MMQC messages.

b. Activities having quantities of these items on-hand will suspend the materiel from issue and use.

c. The CONUS activities will contact the respective manufacturer or distributor for disposition instructions.

d. The OCONUS activities will comply with DoD-MMQC messages. If further disposition instructions are required, report NSN and quantities suspended to:

Commander, USAMMA
ATTN: MCMR-MMB-R
1423 Sultan Dr., Suite 100
FT Detrick MD 21702-5001

except as indicated in para 4-7.f. Reports must include:

(1) MMQC message reference
(2) Nomenclature
(3) Lot or batch number
(4) Quantity
(5) Requisition number under which the materiel was obtained
(6) Purchase order or contract number
(7) Location of the materiel

e. For disposition instructions and advise reporting activities, the USAMMA will coordinate with DSCP or the manufacturer

f. The OCONUS activities may contact the responsible manufacturer or distributor for items procured directly from an overseas acquisition source other than DSCP.

4-8. SUSPENSION OF MEDICAL MATERIEL

a. Suspension instructions

(1) The USAMMA will publish suspension instructions for medical materiel by means of QC messages. When requested, consolidated reports of quantities suspended and quantities involved in a specific action will be submitted by the following:

(a) Each IMSA/MSA/MEDLOG Bn in the continental United States (CONUS). Reports will include all activities logistically supported to include the USAR and the ARNG.

(b) Each OCONUS medical supply activity that submits requisitions directly to DSCP, a supporting commercial distributor, i.e., PV, or the supporting contracting office.

(c) Other activities listed for action on DoD QC messages.

(2) Consolidated reports will be submitted to:

Commander, USAMMA
ATTN: MCMR-MMB-R
1423 Sultan Dr., Suite 100
Fort Detrick MD 21702-5001

unless another reply point is specifically cited in the action document.

b. Accountability. Upon receipt of messages, IMSA/MSA/MEDLOG Bn/ the USAMMCE personnel will account for suspended materiel as follows:

(1) Enter the appropriate data in the message register. Verify the message number against the register to ensure that all messages were received.

(2) Suspend the issue and use of stocks designated. Additionally, all customers will be instructed to suspend all stocks designated. Suspended stocks will be physically segregated from other stock and identified as suspended.

c. Reinstatement of previously suspended materiel. When the USAMMA announces that suspended materiel is serviceable for its intended purpose, the stock affected will be returned to usable status.

4-9. DISPOSAL AND DESTRUCTION

a. The preferred method of destruction is using contracted services for disposal of unserviceable medical materiel. In the event that the item(s) cannot be disposed of using contracted services, then local destruction of unserviceable medical materiel is authorized. Local destruction is restricted to those items approved by the Environmental Science Officer (ESO) of the Preventive Medicine (PM) Service consultants or ESO from the RMC/MSC.

b. The IMSA/MSA/MEDLOG Bn/USAMMCE will accept items for destruction from any activity that is not capable of accomplishing destruction actions. This acceptance constitutes informal accountability and storage by the IMSA/MSA/ MEDLOG Bn/USAMMCE pending review by the ESO destruction officer. The IMSA/MSA/MEDLOG Bn/USAMMCE will sign the DA Form 3161 (Request for Issue or Turn-In) from the activity to show acceptance and storage of the items pending environmental review and destruction.

c. Medical materiel accepted by the IMSA/MSA/MEDLOG Bn/USAMMCE will be recorded on a DA Form 3161, prepared by the activity desiring destruction per this regulation and clearly marked "**FOR DESTRUCTION PURPOSE ONLY**" (see Table 4-2). Document numbers for the DA Form 3161 will be assigned by the activity preparing the document. The IMSA/MSA/MEDLOG Bn/USAMMCE will also assign a voucher number to the document (considered a debit/credit voucher and not posted to the accountable records) for internal control and filing.

d. Medical materiel authorized for destruction will be processed as follows:

(1) The fixed facility HCA or deployable unit commander will appoint a disinterested officer (E7/GS 07 or above) to be responsible for all destruction at the IMSA/MSA/MEDLOG Bn/USAMMCE or deployable unit and for controlled substances at the user level.

(2) The ESO/destruction officer will certify as to the accuracy of all facts entered on destruction documents. Units not authorized TAMMIS-Medical Supply (TAMMIS-MEDSUP/DMLSS) may use DA Form 3161 as their destruction document (see table 4-2). Activities using TAMMIS-MEDSUP/DMLSS will use the system-generated destruction document. The statement shown in figure 4-1, signed by two

witnesses, will be placed on the destruction document below the signed certificate of the ESO/destruction officer.

e. The MIDI/MEIS provides guidance for the destruction of materiel. If a method of destruction code is required but not assigned, contact:

Commander, U.S. Army Center for
Health Promotion and Preventive Medicine
ATTN: MCHB-TS-EHM
5158 Blackhawk Rd.
Aberdeen Proving Ground MD 21010-5403

Items included are as follows:

(1) Unidentifiable items or items which, when intended to be disposed of, are hazardous wastes according to criteria developed under the authority of Public Law 94-580 and its implementing Federal and state regulations, such as parts 260-270, title 40, Code of Federal Regulations (40 CFR 260-270).

(2) Partially used items that are excess. These items tend to deteriorate faster after the opening of a container. The packing list or attached covering label may not actually describe the contents of the container.

(3) Items that have exceeded their shelf life and do not qualify for potency extension projects per this chapter. A list of items currently approved for testing in the Shelf Life Extension Program is available on the USAMMA's website at **http://www.armymedicine.army.mil/usamma**; select DOD/FDA SLEP on sidebar.

(4) Items cited for destruction by the USAMMA QC messages and the SB 8-75 series.

(a) When a contractor disposes of hazardous waste, contracts will contain a statement requiring the contractor to furnish a certificate of destruction with the invoices for payment. Follow-up will be made on the status of destruction when invoices are received without a certificate of destruction.

(b) A witnessing statement on the DA Form 3161 is not required when a contractor accomplishes destruction of hazardous waste.

(c) Local controls will be established to ensure that the contractor is given an itemized listing indicating the product identification number, nomenclature, unit of issue, quantity, and shipping weight of all items to be picked up for destruction. This listing will be filed with the required DA Form 3161.

(5) The completed DA Form 3161 will be used as a voucher for dropping the materiel from accountability. It will cite the reason for destruction, method of destruction (disposal code) (MIDI), and the location of destruction.

(6) When instructed by the USAMMA or DSCP, the medical activity will submit certificates of destruction. Where credits are involved, the local finance and accounting division must also submit MILSTRIP document identifier code (DIC) FAE (request for billing adjustment) transaction. This transaction generates interfund

credits from the DSCP while the certificate is used by the DSCP to support claims for reimbursement against contractors. (See AR 725-50.)

(7) The Chief of Preventive Medicine Service (or designated representative(s)) will review destruction documents from HCA customers and certify that the destruction codes assigned to the items are correct. The installation environmental coordinator will review destruction documents from deployable units that have the capability of performing their own destruction actions. The destruction codes will be checked using the publications stated above. The following statement will be cited on all destruction documents and will be signed by the ESO or installation environmental coordinator:

"I certify that the destruction codes assigned to the above items are acceptable, environmentally sound, destruction/disposal methods for this materiel, and comply with Federal, state, and local laws".

(8) Materiel in less-than-unit-of-issue quantity will be informally accounted for pending destruction. Keep a copy of the turn-in document with the materiel until destruction. Upon destruction, file the copy with the destruction certificate.

(9) Note R and Q drugs less-than-unit-of-issue quantities will not be turned in to IMSA/MSA/MEDLOG Bn/USAMMCE. They will be returned to the supporting pharmacy for destruction.

Table 4-2. Steps to Preparing DA Form 3161 as a Destruction Document

Step	Description
1	Sheet Number: Self-explanatory.
2	Number of Sheets: Self-explanatory.
3	Voucher Number: Self-explanatory.
4	Send to: Destruction.
5	Request from: Activity/unit desiring destruction.
6	Item Number: Self-explanatory.
7	Stock Number: Enter NSN, MIIN, NDC, UPN, or MCN.
8	Item Description: Brief nomenclature, manufacturer, lot number, expiration date/manufacture date, reason for destruction (e.g., expired, MMQC message, manufacturer's recall, broken, nonreturnable excess).
9	Unit of Issue: Self-explanatory.
10	Quantity: Enter quantity to be destroyed.
11	Code: Destruction Code from the MODF, U.S. Army Center for Health Promotion and Preventive Medicine, or activity ES/PM officer. If the code is obtained from other than the MODF, state from whom and when.
12	Supply Action: The quantity actually destroyed. Entered by Destruction Officer.
13	Unit Price: Self-explanatory.
14	Total Cost: Self-explanatory.
15	Sheet Total: The sum of all lines on the sheet.

(continued) **Table 4-2. Steps to Preparing DA Form 3161 as a Destruction Document**

Step	Description
16	Grand Total: The sum of all sheet totals for the same voucher number.
17	The document will be closed with either "LAST ITEM" or "NOTHING FOLLOWS."
18	The certificate of the destruction officer will begin on the next available line or on a continuation sheet. The certificate will be signed and dated. The typed name and grade of the destruction officer will be entered. The certification statement should state specifically how each line was destroyed following the codes assigned and definitions provided in the SB 8-75 series. **Note**: If the items are turned over to a contractor for destruction, the name of the contractor will be shown, the destruction certificate will be changed to reflect this action, and the representative will sign for receiving the items in the presence of the two witnesses.
19	If the materiel is buried in an on-post landfill, the grid coordinates of the site will be shown. If using an off-post landfill, include specific address (street, city, state) and grid coordinates. If the materiel is incinerated, include the on-post building number or specific off-post address.
20	The witnesses' statements will start on the next available line. The statement will be signed and dated by both witnesses. Be sure typed names and grades are shown.
21	The certification of the ESO/destruction officer will begin on the next available line. When an ESO is not assigned, the appointed Destruction Officer will sign the certification. This certification is required for Federal, state, and local environmental standards.
22	Add a statement on the destruction document that credit was sought but not granted if the destruction includes nonstandard drugs or biologicals with a line acquisition value of $100 or more and replacement or credit was not obtained.

Below in Figure 4-1 is an example of how the Destruction Statement Format should be written.

I have witnessed the destruction of the materiel described and it was destroyed on the date and in the manner stated.

(Signature--Witness 1) _____
(Signature--Witness 2)_____

Figure 4-1. Destruction Statement Format

4-10. SUBMITTING MEDICAL MATERIEL COMPLAINTS

a. All medical materiel complaints, regardless of procurement source, will be submitted on a SF 380 (see figure 4-2) to DSCP via online method.

b. Standard Form 380s completed on nonstandard items procured through DSCP must cite the purchase order number and document number. This SB 8-75 contains examples and additional information.

c. Report the circumstances of Type I complaints immediately to DSCP, through the quickest means, that is, by telephone or immediate message.

(1) During normal duty hours (0730-1600 hours Eastern Time), call the DSCP Emergency Supply Operations Center at DSN 444-2112, or commercial 215 737-2112. A facsimile may also be sent to commercial 215 737-2081/7109 or DSN 444-2081/7109.

(2) After duty hours, the numbers called above will automatically transfer to the Staff Duty Officer. If the transfer does not occur or the call is not answered, call the following numbers: DSN 444-2341 or commercial 215 737-2341.

d. The HCA submitting Type I complaints will document the call immediately on SF 380 and send written confirmation within 12 hours via facsimile or on-line at **http://www.armymedicine.army.mil/usamma**. When a Type II or III complaint is determined appropriate, the medical unit will submit the SF 380 within 48 hours.

e. Include photographs and drawings of equipment with Type III complaint SF 380s to help describe or substantiate the complaint.

f. Include a specific statement on the storage conditions of the materiel on the Type II complaint SF 380s. An example of the statement would be as follows: "Controlled temperature warehouse or unheated warehouse."

g. Forward copies of the SF 380 as follows:

(1) Five copies of all complaints regardless of procurement source to:

Director, DSCP
ATTN: DSCP-MRCM
700 Robbins Avenue
Philadelphia PA 19111-5092

(2) One copy of complaints on standard and nonstandard materiel purchased locally to the appropriate local contracting activity.

(3) One copy of complaints for GSA catalog materiel to the GSA regional office.

(4) Information copies of all complaints will be sent to:

(a) Staff Director, JRCAB
1423 Sultan Drive
Fort Detrick MD 21702-5013

(b) Commander, USAMMA
ATTN: MCMR-MMB-R
1423 Sultan Drive, Suite 100
Fort Detrick MD 21702-5001

h. Electronic filing of an SF 380, with simultaneous copies going to DSCP and the USAMMA, is available through the INTERNET at **http://www.armymedicine.army.mil/usamma**.

i. Medical materiel complaints submitted on SF 380 are exempted from information requirements control under AR 335-15.

j. The 21 CFR prescribes reporting certain materiel/equipment conditions to the FDA under the Safe Medical Devices Act (SMDA). Logistics personnel will coordinate and provide a copy of the SF 380 to the Risk Manager as part of the Risk Management Program. The Risk Manager is required under Joint Commission on Accreditation of Healthcare Organization (JCAHO) to review the SMDA information on the SF 380 and assess the potential risk.

k. Additional reports may be required under AR 385-40.

SF380 - Reporting & Processing Medical Materiel Complaints Quality Improvement Report

Complete the following pertinent items. When finished, click on the "Submit" button at the bottom. That's all there is to it. It might be a good idea to click on your web browser's **Print** button to obtain a hard copy of this page for your files before submitting the information for processing.

Further instructions for completion of the SF380.

Submission Date

Assigned Document Number

To:
Defense Supply Center Philadelphia
ATTN: DSCP-MRCM (SF380 Med Mat'l Complaint)
700 Robbins Avenue
Philadelphia, PA 19111-5092

From:

Type of Complaint ☐ I ☐ II ☐ III

Name and Address of Manufacturer

Contract No. or Purchase Order No.

DoD Requisition No.

Lot No(s). *(of defective lots being reported)*

Manufacturer's Serial No.

Part or Model No.*

Date Packed	Expiration Date	Quantity On Hand**	Quantity Suspended

* For pharmaceuticals indicate either the NDC or UPC numbers
** Total quantity including suspended and usable material

Complete Following Items For DoD Type I Complaints Only

Total # Patients Involved	Total # Reactions	Severe or Unusual Reactions	Reactions Requiring Hospitalization

Length of Hospitalization	Vaccine ☐ INITIAL ☐ BOOSTER	Interval

NOTE: TYPE I complaints must be followed up with a hard copy submission.

Cause of Complaint - Explanation of unsatisfactory condition, deficiency, or description of reaction)

Initiator's Name

Autovon/DSN Phone

Comm. Phone

FAX:

E-Mail Address

Supply Officer's Name

Autovon/DSN Phone:

Comm. [illegible]

X:

E[illegible]Ad

Recommendations and/or additional remarks. *(Include any other information or comments you think would be of help to us)*

Be sure to click on your browser's "Print" button to make a copy of this document for your records before submission.

Submit Start over

CHAPTER 5. MEDICAL EQUIPMENT MANAGEMENT

5-1. PROPERTY ACCOUNTABILITY AND MANAGEMENT

a. Rented, Leased, and Loaned Equipment: The Property Book Officer (PBO) will establish property accountability for this equipment within three working days after receipt, regardless of the length of the lease, rental, or loan agreement. Identify this equipment with the appropriate ownership code in accordance with system procedures.

(1) The PBO will maintain a leased equipment file for each contract IAW AR 710-2. The PBO will establish similar folders for rented and loaned equipment. For medical equipment, include a copy of the maintenance acceptance inspection work order in addition to the documents required by AR 710-2.

(2) A lease/purchase analysis is required for each lease/rental over 60 days in accordance with the Federal Acquisition Regulation, subpart 7.4. A copy of the lease/purchase analysis will be kept in the leased equipment file.

5-2. EQUIPMENT RECEIPT PROCESSING

a. All accountable property items will be processed through the organization's Property Book Officer so that the control and accountability for the property can be established and maintained.

b. When accountable property is received, the PBO will:

(1) Update the property records: File the receipt document in the supporting document file to support the increase to the property accounting records. Submit a work order to the medical maintenance branch for a Technical Inspection (TI) of all medical equipment.

(2) Medical maintenance personnel will perform a TI of the equipment to ensure the delivered equipment is in accordance with the specifications of the contract, operational, and safe for patient use. Attention to detail should be given to this process as some equipment may require vendor installation and any package opened may void the contract. A complete TI, if possible, will be performed within four (4) workdays of receipt of the work order by medical maintenance.

(3) Upon release of the equipment by medical maintenance, arrange for delivery to the using activity and obtain the hand receipt holder/custodian's signature on the hand receipt transaction register/custodial actions list or DA Form 3161, if equipment is issued before the hand receipt transaction register/custodial actions list is produced. Equipment requiring an extended storage period before installation or acceptance can occur, will remain the custodial responsibility of the Property Book Officer until installation and acceptance are completed.

(4) File the signed copy of the hand receipt transaction register/custodial actions list or DA Form 3161 in the applicable hand receipt/property custodian file. Destroy this copy when the item appears correctly on the hand receipt/custodian receipt/locator list and the hand receipt holder/custodian has signed it.

c. No equipment will be delivered directly to the end user. However, should such delivery occur, the end user/hand receipt holder/custodian is required to notify the Property Book Officer immediately. Local instructions will be published to inform customers of this requirement. The PBO will coordinate the proper receipt and inspection with the appropriate supply support activity and medical maintenance, if applicable.

d. Receipts for accountable property must be posted to the property records within three working days of receipt of the item. The three working days begin when Property Management personnel physically receive the item as signified by the date the receiving document is signed. No delay in the receiving process is authorized for technical inspection of the equipment either by the vendor or Medical Maintenance Branch.

e. Concern for voiding a manufacture's warranties as a result of opening packages to obtain receipt data is not reason for delay in posting items to the property book. While it is important not to unpack equipment prior to the arrival of a vendor who is contractually bound to assemble or install the equipment, this does not prevent recording the receipt of the equipment. Information from the receipt document or packing list accompanying the equipment should be used to process an initial receipt. When the vendor installs the equipment, the initial receipt can then be adjusted with the actual data required to properly account for the item on the property book.

f. In this way, both accountability and responsibility for the equipment are established without invalidating the warranty. The longer equipment remains unaccounted for at an activity, the higher the probability for theft, diversion, or misappropriation.

5-3. ORGANIZATIONAL CLOTHING AND INDIVIDUAL EQUIPMENT (OCIE) WAIVER PROCEDURES

a. All MEDCOM activities/units located on an installation with a Central Issue Facility (CIF) must seek and obtain OCIE support from the supporting CIF. Coordination should be made with the supporting CIF to transfer on-hand property book OCIE items and determine specific method of support; support levels and means or reimbursement must be documented on an Installation Support Agreement. When the activity/unit is not located on an installation, or located on an installation without a CIF, and the distance is such as to cause significant inconvenience/hardship, the activity/unit must request authorization to maintain OCIE as an exception to policy.

b. The request must explain why installation support is not used. Along with the request for an exception to policy, the Activity/Unit must submit its written operating procedures for the unit OCIE Issue Point in accordance with AR 710-2, DA Pamphlet 710-2-1, and AR 735-5. The exception to policy must be submitted through formal channels beginning with the applicable Regional Medical Command (RMC) or Major Subordinate Command through MEDCOM to the DA. The MEDCOM will review and submit to DA (for approval/disapproval) only those exceptions to policy, which meet the criteria identified above.

c. Commanders authorized to maintain OCIE on their property books will follow procedures described in DA PAM 710-2-1, Chapter 4 and 10, to account for and assign responsibility of OCIE, respectively.

5-4. MEDICAL MATERIEL BENEFIT PROGRAM (MMBP) LOAN PROCEDURES

a. Activities maintaining equipment accounting record using the Army Medical Department Property Accounting System (AMEDDPAS) or the Defense Medical Logistics Standard Support (DMLSS) system will manage MMBP loans in accordance with the applicable systems operating procedures.

b. Activities using manual equipment accounting records or an automated system without a specific MMBP loan process will account for and record MMBP property loans as follows:

(1) MMBP property will be listed on a separate hand receipt.
(2) MMBP property lent to a patient will be listed on DA Form 3161.

(a) Block 2 of DA Form 3161 will reflect the complete name, address, category, telephone number, and social security number of the borrower.

(b) DA Form will have, in addition to a listing of the equipment lent, the following statement:

> I hereby acknowledge acceptance of the above-listed Government–owned equipment received in good working order and repair, for temporary use. During the period (___enter date ___) to (___ enter date ___). I understand that I am responsible for proper care and safekeeping of the equipment and will promptly return it/them in the same condition as received, fair wear and tear expected, upon termination of the loan period specified unless an approved extension is obtained, or at such earlier date as I may elect. In the event of loss, damage or destruction of the equipment through fault or neglect, I agree to reimburse the Government the cost of repair or fair market value of the equipment as appropriate.
>
> I have been informed that periodic maintenance services are required to be performed (insert frequency). Service is required (_____ enter dates _____). When feasible, it is my responsibility to transport the equipment to (_____insert HCA_____) to obtain the required services. Prior arrangements by telephoning (___number___) for services should be made. If I relocate to another area and will receive medical care from another Federal health care facility, I must notify (___ insert property manager _____) so that equipment transfer can be accomplished and designation of a new supporting maintenance activity can be established.
>
> It is further understood that the equipment on loan is not to be permanently removed from the address indicated in block 2 of the hand receipt without prior authorization of the commander (name of the HCA).
>
> (Signature of patient or sponsor)

(c) DA Form 3161 will be prepared in duplicate and signed by the patient or sponsor accepting the loan. The MMBP manager will keep the original

copy with the written prescription or letter. The second copy will be given to the borrower.

(d) MMBP Reconciliation: The physical inventory of MMBP equipment on loan is not required. However, equipment on loan will be reconciled each year to verify the accuracy of property book and hand receipt balances. Reconciliation may be accomplished telephonically or by certified mail. If all efforts to reconcile lent MMBP property fail, obtain relief from property accountability through procedures in AR 735-5.

5-5. OXYGEN FOR HOME USE

a. Oxygen and oxygen related supplies that are provided to outpatients for home use may be provided pursuant to the availability of funds by one of the following methods:

(1) The HCA may contract with a local oxygen supplier to provide complete home service. This service should include safety and operating instructions, gas cylinders, tubing, regulators, maintenance, and all other related supplies.

(2) When a HCA does not contract for home oxygen service, government-owned cylinders and equipment may be provided for outpatient use. If this method is used, follow these guidelines:

(a) Establish local procedures to provide safety, operating and refill procedures as well as tubing, regulators, and other necessary supplies.

(b) Establish procedures for medical maintenance to inspect regulators and other oxygen related equipment prior to issue or loan to the patient, during home use, and upon return of the equipment to the HCA.

5-6. MANAGEMENT OF CAPITAL EQUIPMENT

a. Accountability and Financial Reporting of Capital Equipment: Equipment that is defined as investment or capital equipment is required to be accounted and reported for capitalization and depreciation in accordance with the 1990 Chief Finance Officer (CFO) Compliance Act. MEDCOM is responsible for reporting medical investment equipment accounting information to Defense Finance and Accounting Service (DFAS) annually for all MEDCOM activities.

b. Automated property accounting system user will adhere to their automated system’s procedures when entering investment/capital equipment into the system.

(1) Depreciation: Depreciation of investment equipment is calculated by the automated property accounting system (AMEDDPAS or DMLSS), based on a straight-line depreciation method over a five-year life. Fully depreciated equipment will have zero depreciation at the end of the five years and will no longer be reported. The useful life of 5 years does not change the life expectancy for the equipment listed in TB MED 750-1.

(2) Determination of Acquisition Cost: Original acquisition cost includes all costs incurred to bring capital equipment into service for its intended use. These costs include amounts paid to vendors, transportation to point of initial use, handling and storage costs, interest costs paid, direct and indirect production costs, installation costs, and training costs.

(3) Investment equipment acquisition date (in service date) is the date when the title for the equipment passes to the Army or when the item is delivered to the Army or to an agent of the Army. Investment equipment acquired under a capital lease should be recorded as an asset at lease inception. For constructed assets, the "acquisition date" should be the date the asset is placed in service.

(4) Supporting document files: Documentation for all transactions affecting the capital value of the equipment will be kept in physical files throughout the life of the asset (e.g., contracts, invoices, site-prep, installation, production engineering, etc.) to include documentation related to disposals, transfers in from other federal activities, exchanges, and trade-ins. This file must be maintained for the entire life of the equipment. If you keep the equipment for 20 years, the file must be maintained for 20 years. These files are maintained as an exception to the MARKS guidance.

(5) Improvement Costs: Only add the value of upgrades/improvement costs if equal to or greater than $100,000.

(6) Transportation costs for lateral transfers: This cost must be added to the equipment CFO RECORD for a single piece of equipment or to the system line ("AA") if it is a system. Do not add it to the component lines. The losing PBO must request a copy of the Government Bill of Lading showing the transportation cost, shipping and handling from the Installation Transportation Office (ITO). For shipments containing multiple items, ask the ITO to list the costs of the individual items of equipment, if possible. If the ITO cannot provide the separate lines, then pro-rate the cost to each item by dividing the total cost equally among the items and input to the CFO RECORD. If the transportation cost is not available at the time of shipment, the losing PBO will, upon receipt of the transportation costs, adjust the equipment record. Print and fax a copy of the adjusted CFO RECORD to the gaining activity with the added transportation cost. The transportation costs are depicted on both property books, as a loss to the loosing activity and a gain to the receiving activity.

c. Capital Equipment Transfer: When transferring equipment between Property Books, data required by the CFO Act must be entered on the applicable lateral transfer document (DD Form 1149 or DA Form 3161). Data elements required in addition to identification data elements are:

(1) Acquisition Cost – required
(2) Residual Value – optional (only required if assigned by losing activity)
(3) Transportation Cost – optional (only required if assigned by the losing activity)
(4) Improvement Cost – optional (only required if assigned by the losing activity)

(5) Accumulated Depreciation – mandatory

(6) Accumulated Improvement Depreciation – optional (only required if assigned by losing activity. If there is an Improvement Cost there must be Accumulated Improvement depreciation.)

d. All documentation must accompany equipment when it is transferred. This includes the documents from the supporting document file, MEDCASE file and a copy of the CFO Record. Copies of supporting documentation shall be retained by the transferring activity; the originals are forwarded to the gaining activity. The gaining PBO must contact the losing PBO if this documentation isn't received with the equipment.

e. The lateral transfer loss is not removed from the loosing activity accountable records until a copy of the signed DD Form 1149 or DA Form 3161 is received from the gaining PBO.

f. Capital Equipment Leases: Capital leases are leases that transfer substantially all benefits and risks of ownership to the lessee. If, at its inception, a lease meets one or more of the following four criteria, the lessee should classify the lease as a capital lease.

(1) The lease transfers ownership of the property to the lessee by the end of the lease term.

(2) The lease contains an option to purchase the leased property at a bargain price.

(3) The lease term is equal to or greater than 75 percent of the estimated economic life of the leased property.

(4) The present value of rental and other minimum lease payments, excluding that portion of the payments representing executor cost, equals or exceeds 90 percent of the fair value of the leased property.

g. If the leased equipment meets any one of the four criteria for capital lease, identify it on the automated property records as such in accordance with the system procedures. The acquisition cost will be the actual cost of a like item or the fair market value if no like item is available. An acquisition cost is required regardless of the type of lease. Leases not meeting the above criteria are classified as an operating lease. Operating leases are leases in which the activity does not assume the risks of ownership of the equipment. Multi-year service contracts and multi-year purchase contracts for expendable commodities are not capital leases.

h. Turn in of Investment Equipment: Reporting and turn in of investment equipment is processed IAW AR 710-2 and AR 40-61. All documentation will be transferred with the equipment when turned-in to the supply support activity or Defense Reutilization and Marketing Office (DRMO). The PBO will retain a copy of this documentation on file along with the turn-in documentation.

5-7. HAND-RECEIPT HOLDER/CUSTODIAN PROCEDURES

a. Acceptance of and relief from custodial responsibility for accountable property will be accomplished as follows:

(1) When hand receipt/custodial responsibility is to be assumed, the PBO will provide the hand receipt holder/custodian with a Hand Receipt/Custodian Receipt/Locator Listing showing all property charged and due in to the hand-receipt/ custodian account. Upon signing and dating the listing, the hand-receipt holder/ custodian assumes responsibility for all in-use items in the quantities indicated and verifies the requirement for all due-ins on the listing. The hand receipt-holder/ custodian will return the original signed listing to the PBO and retain a signed copy as a record of equipment authorized and on hand or due in. As items are issued to or turned-in from the account, the hand-receipt holder/custodian will keep a signed hand receipt transaction register/custodian action list or DA Form 3161 showing the action taken, until the item is correctly listed on the applicable hand receipt/ custodian receipt/locator list at which time it may be destroyed.

(2) The hand-receipt holder/custodian will ensure, by spot check and periodic inventory, that all property in the account is properly charged to the account, is physically on hand or that appropriate action has been taken to effect settlement for missing or damaged items.

(3) Before a hand-receipt holder/custodian is relieved from duty, transferred, separated from service, or absent from the account for a period longer than 30 days, the PBO will transfer the property to an authorized successor. The hand-receipt holder/custodian will not be relieved of property accountability responsibility until officially cleared by the PBO.

b. Contractors or contractor's personnel shall not be Hand-Receipt Holders/ Custodians for equipment listed on a MEDCOM activity's property books. A contractor can only have responsibility for specifically identified Government Furnished Property (GFP) provided to the contractor under the terms of the contract.

5-8. MANAGEMENT OF SYSTEMS AND COMPONENTS

a. Accountable property should be recorded on an item-level basis (i.e., each individual item in a separate record). However, when considered advantageous to do so or required to comply with capital equipment reporting requirements, records will be maintained on a system basis.

(1) The system method may be used when:

(a) Two or more individual items (equipment components) are part of a system; and

(b) The system is considered to be incomplete or inoperable in the absence of any one of its component equipment items.

b. When establishing a system on the property book using AMEDDPAS, do the following:

(1) The stock number for the system "AA" line shall only have a quantity of one. The "AA" line names the function of the system and stores the total cost for the system but is not a physical piece of equipment.

(2) If an identical system is to be put on the property book, the system line is "BA" and so on.

(3) AMEDDPAS users will record the total cost of the system on the "AA" line. Components will have a unit cost of zero. Maintenance records on medical equipment in AMEDDPAS are maintained on the system as a whole. The system "AA" line is assigned subsystem code B to designate it as a maintenance significant item. Components are assigned subsystem code A indicating no medical maintenance service required.

c. DMLSS users will adhere to the following procedures to establish a system on the property book.

(1) Establish a due in for the item in accordance with DMLSS procedures.

(2) Receive the system in accordance with DMLSS and local procedures. Identify this as a System item (System ECN). This is an actual item and should be the major item of the system.

(3) Gain the other components of the system using the DMLSS ETM Gain module with the reason "Component Gain" with the actual price of the component. Ensure the components are associated with the system ECN.

(4) Return to the system record and select the Acquisition Cost icon and adjust the purchase price to reflect the cost of the major item recorded there.

(5) Select the System ECN record in the Equipment Search screen. Selecting the Print icon and then the Detail button generates a report for the ECN. This report lists the system and components for the selected system record and displays the Total System Acquisition Cost. The Systems and Components report, in the Standard Inquiry portion of the Reports module, also shows this information. The Components tab of the System ECN tab will show the total system acquisition cost.

(6) Identify components requiring medical maintenance services. Update the catalog record to signify which components require maintenance services.

5-9. TURN-IN OF EXCESS EQUIPMENT

a. Medical equipment reported in accordance with Chapter 3 of this SB not being transferred to another activity or is unserviceable, and cannot be economically repaired, may be turned-in directly to the DRMO.

b. Turn-in Procedures

(1) The PBO shall prepare a DD Form 1348-1A (Issue Release/Receipt Document) in accordance with DOD 4160.21-M.

(2) The property and a properly prepared DD Form 1348-1A will be taken to DRMO where the document is stamped/signed to verify receipt. An unsigned/ unstamped (by DRMO) DD Form 1348-1A is not acceptable as a supporting document for the loss.

(3) The equipment will be removed from the property book following the automated procedures for the applicable system.

(4) Periodically, the PBO shall obtain a listing of all equipment received by DRMO from his/her activity and compare that listing to activity records to ensure that all items sent to DRMO were properly documented and processed in the property system. The PBO should resolve any errors within 5 business days. The reconciliation records should be maintained in the property records until the next reconciliation.

5-10. LATERAL TRANSFER PROCEDURES

a. Activities may laterally transfer excess equipment with a unit price less than $350,000 within the MEDCOM without reporting as excess if they have identified a gaining activity. Activities will report excess equipment command wide if they cannot find a gaining activity. Procedures for excess reporting are in Chapter 3.

b. The losing activity commander signs the lateral transfer document as the approving authority. The Regional Medical Command (RMC) can withdraw or modify lateral transfer authority from its activity commanders. The RMC commander can supplement these lateral transfer procedures as they see appropriate.

c. The losing activity should ship equipment to the gaining activity within three weeks of disposition instruction receipt. The losing activity is responsible for all shipping costs to transport an item to a gaining activity. Equipment will be shipped in accordance with AR 746-1. Ensure equipment is properly packed, crated, and shipped. Activities receiving damaged equipment will attempt to resolve the situation at their level.

d. Laterally-transferred equipment will include:

(1) Supporting supplies (expendables) and accessories on hand.
(2) Supporting repair parts and listing(s) on hand.
(3) Operator’s manuals, manufacturer’s literature, and technical manuals.
(4) The maintenance history/records to include the work order requesting the excess technical inspection for condition code.
(5) CFO files when applicable.

e. The gaining activity establishes property accountability upon receipt and will return the signed lateral transfer document within 3 days of receipt. They acknowledge receipt by returning the original signed copy of the lateral transfer document to the losing activity. The gaining activity will return the signed copy of the lateral transfer document as soon as possible. The losing activity will place the signed copy of the lateral transfer in the supporting document files.

CHAPTER 6. MEDICAL EQUIPMENT MAINTENANCE

Medical equipment maintenance procedures are published in TB Med 750-1, dated April 1998. For USAMEDCOM units, TB MED 750-1 procedures are further supplemented by Operation Management Bulletins.

CHAPTER 7. ENVIRONMENTAL SERVICES MANAGEMENT IN HEALTHCARE ORGANIZATIONS

7-1. ENVIRONMENTAL SERVICES MANAGEMENT - SCOPE

a. The scope of environmental services (EVS) management in healthcare organizations (HCA) encompasses, at minimum, these core functions:
textile care services,
housekeeping services, and
regulated medical waste disposition.

(1) The Director/Chief of Logistics will have functional responsibility over HCA Environmental Services.

(2) The Chief of Environmental Services will be a qualified hospital housekeeping officer (i.e., GS-673 occupational series) assigned to the HCA staff to manage the EVS integrated functions.

(3) The Army Civilian Training, Education, and Development System (ACTEDS) plan for the GS-673 Occupational Series provides the careerist and management with a guide to assist in career enhancement and progression. Training and development planning is essential in developing and enhancing the Chief of Environmental Service's knowledge, skills, and abilities. The ACTEDS, if followed, will provide all EVS personnel the avenue to become more proficient in the field.

(4) The Chief of Environmental Services will be responsible and accountable for the submission of data to the MEDCOM electronic EVS Program database via the **http:\\www.medlogspt.army.mil** website. Reporting instructions are provided at the website.

7-2. MANAGEMENT OF HCA TEXTILE CARE SERVICES

a. Policy and Procedural Guidance

(1) The following publications will be readily accessible: AR 40-61; AR 210-130; 29 CFR; and, the most current JCAHO Accreditation Manual for Healthcare Organizations.

(2) The Chief of Environmental Services will have functional responsibility for textile care services (linen distribution and laundry services. Reference AR 40-61, paragraph 7-3a).

(3) A Textile Care Services Officer (TCSO), appointed by the Commander, will perform the day-to-day functions involved with management of textile care.

(4) The HCA commander will establish a Linen Management Committee (LMC). The committee will:

(a) Recommend linen management policy and review program performance.

(b) Implement the HCA Commander's policy on management of scrub uniforms.

(5) The LMC may be integrated with other HCA (parent) committees if sanctioned by the commander. However, the LMC responsibilities will be fully performed by the parent committee.

(6) The TCSO will ensure that:

(a) Customers establish stock levels to justify their daily linen requirements.

(b) Customer linen usage is periodically reviewed, and patterns of inappropriate use are corrected.

(c) HCA-owned linen is marked with HCA logo or by other means to identify it as government property.

(d) Contractor-owned and provided textiles are marked as prescribed in the contract.

(e) Policy is established, and enforced by the Linen Management Committee, to prevent the theft, abuse, and misuse of linen.

(f) Clean linen is delivered to the user so as to minimize microbial contamination from surface contact or airborne deposition.

(g) Linen inventories are conducted at least annually for HCA-owned and provided textiles, and that the results are used to evaluate the effectiveness of the linen program.

(h) DA Form 444 or automated equivalent is prepared for HCA-owned and provided textiles to document inventory gains and losses and to adjust informal accounting records.

(i) Inventory results for HCA-owned and provided textiles are reported through the Linen Management Committee to the Commander for appropriate action and approval.

(j) HCA-owned and provided textiles are accounted for on DA Form 1296 or automated equivalent.

(k) DA Form 2064 or automated equivalent and voucher files are used to support all entries.

(l) Records are held for two years after the last posting date and then destroyed.

(m) The contract laundry service provides for textile repair for HCA-owned and provided textiles.

(n) Salvageable HCA-owned and provided textiles are turned-in to the supporting DRMO or converted to rags.

(o) A disinterested officer is appointed on orders to certify that salvageable HCA-owned and provided textiles are converted to rags.

(p) Collection and processing of soiled linen is performed in accordance with the Occupational Safety and Health Administration (OSHA) Blood borne Pathogens standard.

(q) The HCA or contractor, as applicable, has an Exposure Control Plan (ECP), in accordance with 29 CFR 1910.1030 and JCAHO requirements.

(r) The ECP identifies tasks and procedures where textile care services employees may be at risk of encountering occupational exposure to blood borne pathogens.

(s) The ECP is reviewed and updated annually, and it is available to all textile care services employees in the HCA.

(t) The TCSO is designated as the Contracting Officer's Representative (COR) if the linen/laundry distribution service is contracted by the HCA.

7-3. MANAGEMENT OF HCA HOUSEKEEPING SERVICES

a. Policy and Procedural Guidance

(1) The following publications will be readily accessible: AR 40-61, AR 210-130, 29 CFR, and the current JCAHO Accreditation Manual for Healthcare Organizations.

(2) The Chief of Environmental Services, a qualified Hospital Housekeeping Officer (i.e., GS-673 occupational series), will have functional responsibility for HCA Housekeeping services.

(3) The Chief of Environmental Services will ensure that:

(a) The HCA's Infection Control Committee provides written approval in its meeting minutes for all chemical products used by the housekeeping organization.

(b) The housekeeping organization follows prescribed manufacturer-recommended dilution rates when mixing the disinfectant-detergents for prevention of nosocomial infection in patient care areas.

(c) The housekeeping organization follows prescribed contact times when applying the disinfectant-detergents.

(d) The HCA has a current Exposure Control Plan that identifies by position, task, and procedures where housekeeping services employees are at risk of occupational exposure to blood borne pathogens.

(e) The carts or any other reusable containers, used to transport and hold RMW, are cleaned at least weekly using a hospital-grade disinfectant-detergent.

(f) The Exposure Control Plan is available to all housekeeping services employees.

(g) The Contracting Officer designates, in writing, the hospital housekeeping officer (i.e., GS-673 occupational series) as the Contracting Officer's Representative (COR) to quality assure the contractor's performance.

(h) The contractor is paid only for those services, provided under contract, which are bona fide requirements.

(i) Customers promptly notify the COR about rooms that are inaccessible or are not to be cleaned by the contractor are removed from the contract.

(j) The Materiel Safety Data Sheets (MSDS) for cleaning supplies are readily accessible. Note: As a minimum, a current and readable MSDS for each product in use should be located in a binder in each housekeeping closet.

(k) The housekeeping organization properly labels all secondary containers whenever cleaning supplies are transferred from the manufacturer's original container.

(l) The HCA housekeeping officer establishes a random sampling inspection system to evaluate the quality of services received.

(m) A training program is in place for housekeeping employees, and that documentation is maintained on who was trained, and the training topic.

(n) A written cleaning schedule and cleaning procedures exists, based on contract specifications.

(o) The housekeeping organization has been oriented to and educated about the environment of care consistent with its mission, services, and laws/regulations. Note: Be able to provide documentation.

7-4. MANAGEMENT OF HCA-REGULATED MEDICAL WASTE/HAZARDOUS WASTE

a. Policy and Procedural Guidance

(1) In addition to hospital and installation regulations, the following publications will be readily accessible: AR 40-61; AR 200-1; AR 200-1, 1-28(a); Spill/Emergency Plans/Waste Management Plan; Applicable State and Local regulations; MEDCOM Regulation 40-35; 29 CFR; and the current JCAHO Accreditation Manual for Healthcare Organizations.

(2) The Chief of Environmental Services, a qualified Hospital Housekeeping Officer (i.e., GS-673 occupational series), will have functional responsibility for disposition of HCA Regulated Medical Waste/Hazardous Waste.

(3) The Chief of Environmental Services will be responsible for oversight of the collection/segregation of RMW. The Chief of Environmental Services will ensure that:

(a) General waste is segregated from RMW to the extent intended by paragraphs 7 and 9 of MEDCOM Regulation 40-35.

(b) RMW containers are appropriately labeled to identify them as RMW containers (biohazard symbol or red in color).

(c) RMW bags are at least three millimeters thick.

(d) Bags are red in color (or installation-specific color).

(e) RMW bags are tightly sealed before being removed from the points of generation.

(f) Used syringes are placed into rigid, impervious containers without clipping or breaking needles and without recapping.

(g) Sharps containers are removed from service when approximately three-fourths full.

(h) Bags of RMW are collected from outlying clinics (medical and dental) as required.

(i) Government personnel or contractor employees, trained in proper collection and handling procedures, collect RMW at regular intervals.

(j) Carts used to transport RMW within the MTF are cleaned with an EPA registered hospital detergent-disinfectant, either weekly or at a frequency specified by the MTF.

(k) Transport of infectious waste within the hospital is conducted in a manner that minimizes patient and personnel exposure.

(l) Carts are kept closed whenever possible.

(m) RMW generation-weights are tracked by the activity.

(n) RMW weight reports are maintained on file.

(4) The Chief of Environmental Services will be responsible for oversight of the storage and disposal of RMW. The Chief of Environmental Services will ensure that:

(a) Medical waste is stored in a secure, properly identified area that is kept clean and free of pests.

(b) Storage times comply with those specified in MEDCOM 40-35, 9b(4)(b).

(c) Pathological wastes are refrigerated while awaiting pick up for disposal.

(d) Pathological wastes are removed from the refrigerators and disposed of within 30 days.

(e) A written contingency plan exists for RMW disposal.

(5) The Chief of Environmental Services will be responsible for oversight of the treatment of RMW. The Chief of Environmental Services will ensure that:

(a) The method of treatment of the RMW is according to state regulations.

(b) Tracking documents (manifests) are maintained for the number of years required by the state.

(6) The Chief of Environmental Services will be responsible for oversight of RMW transport outside the MTF. The Chief of Environmental Services will ensure that:

(a) RMW is transported only in government or contractor vehicles.

(b) Spill containment kits are maintained in the vehicles.

CHAPTER 8. FACILITY MANAGER'S LIFE-CYCLE MANAGEMENT

8-1. PURPOSE

This Chapter of SB 8-75-11 prescribes United States Army Medical Command (USAMEDCOM) guidelines on the implementation of facility management within MEDCOM.

8-2. HISTORY

This chapter describes the role and responsibility of the facility manager at the installation level. It describes the functions associated with operating, maintaining, repairing, and constructing USAMEDCOM facilities. It is developed as a cradle-to-grave guide for facility management. Accordingly, it is called the life-cycle management guide.

8-3. APPLICABILITY

This SB applies to all United States Army Medical Centers (MEDCENS), medical department activities (MEDDACs), Health Clinics, and all facility management activities within MEDCOM major subordinate commands (MSCs). These include AMEDD Center and School, U.S. Army Center for Health Promotion and Preventive Medicine (CHPPM), U.S. Army Dental Command (DENCOM), U.S. Army Medical Research and Material Command (MRMC), the U.S. Army Veterinary Command (VETCOM), and the Armed Forces Institute of Pathology (AFIP).

8-4. ABBREVIATIONS

See the Glossary at the end of this publication.

8-5. OBJECTIVES

The objectives of this chapter are to:

a. Ensure health care and research facilities are functional, safe, and reliable to meet peacetime and wartime missions.

b. Provide a systematic (life cycle) approach for financing, managing, and maintaining MEDCOM facilities in a cost effective manner.

c. Ensure compliance with appropriate accreditation agencies, such as the Joint Commission on Accreditation of Healthcare Organization (JCAHO) and the Council of American Pathologists (CAP), and applicable standards to include the National Fire Protection Association (NFPA), all Federal regulations, and applicable State regulations.

8-6. SCOPE

a. Facility Life Cycle Management (FLCM) is the process of economically managing facility operations, maintenance, repair, and alterations from the time a facility is constructed until it is demolished in order to maximize productive use of the facility and realize a positive economic return on investment.

b. A sound investment and management strategy is essential in the effective allocation of limited financial and personnel resources, and the successful implementation of a facility life-cycle management program. In order to gage the success of the program and ultimately the mission of USAMEDCOM as a world-class health care organization, components of the program must be evaluated against performance indicators that reflect the best in private and governmental health care facility management. This document is the performance plan for facility life-cycle management.

8-7. FACILITY LIFE-CYCLE INVESTMENT PROGRAM BACKGROUND

a. A 1990 report of the National Research Council*, Committing to the Cost of Ownership: Maintenance and Repair of Public Buildings*, recommended that " … An appropriate budget allocation for (M&R) routine maintenance and repair for a substantial inventory of facilities will typically be in the range of 2 to 4 percent of the aggregate current replacement value of those facilities."

b. Prior to 1990, emphasis within the Department of Army was placed on construction of new military medical facilities. Maintenance and repair was funded at the local activity level and implemented through the installation department of public works. Major declines in installation real property maintenance and repair funding resulted in a deteriorated, aged healthcare facility infrastructure that lacked compliance with regulatory and code statutes. Hospital commanders were placed in a position of providing world-class healthcare with a under maintained and misaligned healthcare facility platform. This translated into a need to completely revise the facility investment program.

8-8. FACILITY LIFE-CYCLE INVESTMENT PROGRAM OBJECTIVE

The objective of the facility life-cycle investment program to provide a balanced level of sustained investment that will result in a reliable facility inventory. Reliability in this context refers to both the systems and components that operate with very limited negative impact (downtime) to critical systems supporting patient care and to a healthcare facility platform that supports the Army Medical Departments mission in space requirements. "… Facility investment should be directly linked to Agency mission. …" according to a 1998 publication by the National Research Council, Stewardship of Federal Facilities.

8-9. FACILITY LIFE-CYCLE INVESTMENT PROGRAM ELEMENTS

The facility investment program is divided into two general areas. It is defined in accordance with current Department of Defense program elements of sustainment,

restoration, modernization, and includes medical military construction. The areas are:

a. Maintenance and repair activities: Sustainment is defined as maintenance and repair activities necessary to keep a typical inventory of facilities in good working order over a 50-year service life. It includes regularly scheduled adjustments and inspections, preventive maintenance tasks, and emergency response and service calls for minor repairs. It also includes major repairs or replacement of facility components that are expected to occur periodically throughout the facility life cycle. Sustainment does not include facilities operations (such as custodial services, grass cutting, landscaping, waste disposal, and the provision of central utilities).

b. Capital investment improvements: Capital improvements can be further subdivided into restoration and modernization. Facilities restoration and modernization provides resources for improving an inventory of medical facilities and installations with a primary mission of health care.

(1) Restoration includes repair and replacement work to restore damaged facilities due to accident or failure attributable to inadequate sustainment, excessive age, or other causes.

(2) Modernization includes alteration of facilities to implement a new, higher standard (including regulatory changes), to accommodate new functions, or to replace building components that typically last more than 50 years (such as foundations and structural components).

8-10. FACILITY LIFE-CYCLE INVESTMENT PRIORITIES

SRM program elements must be prioritized to ensure maximum effective use of available resources. They are prioritized as follows:

a. Scheduled maintenance (often termed preventive maintenance) is given the highest funding priority, since it significantly improves reliability of systems and components and diminishes the risk of unscheduled outages impacting patient care. Preventive maintenance is the baseline for supporting continuity of healthcare operations.

b. The next priority is given to scheduled major repair. Deterioration, caused by many factors including operational usage and environmental conditions, will eventually diminish system performance below a required level. Equipment and major systems must be repaired by major overhaul or replaced. Both scheduled major repair and preventive maintenance makeup sustainment of facilities.

c. The next priority is termed restoration. This element holds a priority level below sustainment provided sustainment is being performed. Facilities that are not maintained experience accelerated deterioration, in much the same manner as an automobile whose oil has never been changed. In addition to lack of maintenance, manufacturer’s flaws, poor installation, and adverse environmental conditions can cause equipment breakdown before normal life expectancy. Since restoration involves repairs to damaged components or equipment caused by accident or failure

attributable to inadequate maintenance, it is very difficult to manage. However, it can be managed through a standardized facility assessment program.

d. Requirements for modernization of healthcare facilities have changed significantly as population demographics have shifted and the mission of the Army Medical Department has changed. Funds for modernization can be operations and maintenance-based or military construction-based depending on the statutory requirements imposed on these programs. Under any funding scenario, modernization is a capital investment that is managed as a long-term requirement.

8-11. FACILITY LIFE-CYCLE INVESTMENT ALLOCATION PRINCIPLES

For use at the programmatic level, the life expectancy of healthcare facilities has been established at 50 years. This may change in the future. In reality, the life expectancy of facilities will vary depending on many factors. A 50-year life expectancy implies facilities will be replaced at an average funding level of about 2 percent of plant replacement value (PRV).

a. Referencing the 2001 publication by Whitestone Research, "*Building Maintenance and Repair Costs*", repairs for major components are required in typical hospitals between 20 to 30 years (average 25 years). Integrating projects consisting of both major repairs and modernization during this period can be a very effective cost avoidance technique. Often, without proper planning and requirements integration, upgrades to the infrastructure do not interface with space changes required for modernization. The results are obvious.

b. The investment strategy can be easily condensed and restated in terms of percentages of Plant Replacement Value (PRV). PRV provides a means of recognizing widely varying facility conditions with the goal of an annually adjusted process that calculates rate of investment over a period of time. PRV can be adjusted to account for size of facility, relative location, makeup and complexity of infrastructure, contingencies for support facilities, fixed equipment, engineering and architectural cost, and economic conditions, such as inflation. It represents the sum of costs, by facility type and location, to replace the inventory in kind. The PRV is also adjusted as facilities close or new facilities come online. The method used in the calculation of PRV is:

PRV = Facility Quantity x Cost Factor x Area Cost Factor x 1.2

Facility quantity (gross square feet for buildings) is based on building inventory recorded in IFS at the installation. Constructions cost factors are listed in the latest version of the DoD Facilities Cost Factors Handbook. Area cost factors, published annually by the Tri-service Committee on Cost Engineering, are a geographic location adjustment factor for costs of labor, material, and equipment. The 1.2 multiplier accounts for supervision, inspection, overhead, and design associated with new construction.

c. Sustainment cost factors are published in the latest edition of the DoD Facilities Cost Factors Handbook. The sustainment requirement for a specific category of facility is:

Requirement = Facility Quantity x Unit Cost Factor x Area Cost Factor x Inflation Factor

The unit cost factor for buildings is given in dollars per gross square feet.

8-12. GENERAL ORGANIZATIONAL OVERVIEW

The organizations primarily involved in the administration of facility life-cycle management within the U.S. Army Medical Command are:

(1) the facility management component and/or logistics division at the activity level,
(2) the Facility Director and/or logistics division at the Regional Medical Command (RMC)/Major Subordinate Command (MSC),
(3) Health Facility Planning Agency (HFPA), and
(4) the Office of the Assistant Chief of Staff for Installations, Environmental, and Facility Management (ACSIE&FM) at USAMEDCOM Headquarters.

8-13. ACSIE&FM

ACSIE&FM is primarily strategic in mission. The ACSIE&FM is the principal staff officer to the U.S Army MEDCOM Commanding General and the Army Surgeon General. The ACSIE&FM is the proponent for MEDCOM installation management. ACSIE&FM has a planning horizon of one to eight (1-8) years. ACSIE&FM interfaces with Army planners, obtains and distributes resources, conveys facility program guidance, policies and priorities, assesses and evaluates facility programs, and takes action to optimize facility investments.

8-14. HFPA

HFPA is primarily operational in mission. As of 01 October 1997, HFPA is in direct support of activity and RMC/MSC restoration, modernization, and major repair functions of sustainment. These functions have a planning horizon of one year. HFPA administers the Medical Military Construction program.

8-15. REGIONAL MEDICAL COMMANDS/MAJOR SUBORDINATE COMMANDS

RMCs/MSCs are both tactical and operational in mission. Tactical functions have a planning horizon of one to two years. RMCs/MSCs are focused on integration of health care and facility planning and compliance with MEDCOM policies and procedures. HFPA directly supports RMC/MSC facility sustainment programs. RMC/MSC facility directors have functions delegated to them by ACSIE&FM. RMC/MSC facility management functions cover the following areas:

a. Facility assessment and oversight
b. Major repair and Restoration, Modernization program
c. Medical Military Construction Program
d. Technical assistance
e. Facility management program execution

8-16. SUSTAINMENT

a. Sustainment is the process of planning, programming, and executing those programs necessary to maintain the infrastructure of a facility from the time it is constructed until retirement. Within this context, sustainment can be viewed as a cyclic process from which financial and personnel resources are used to provide reliable systems and an aesthetically sound, safe, and functional environment.

b. Sustainment involves the cycle of on-going, routine repair, alteration, maintenance and operation of the facility. It encompasses maintenance and minor repair, some major repair, and some minor construction.

8-17. FACILITY STAFFING AND ORGANIZATION

a. Each Medical Treatment Facility (MTF), medical center (MEDCEN), and research facility shall establish and staff a facility management section proportional to his or her facility support requirements. In MTFs, it is recommended that the section be either a branch established in the logistics division or organized under the Deputy Chief of Administration (DCA) or Chief of Logistics. In research facilities, it is recommended that the facility management section be organized under the logistics division.

b. Facility Management Branch (FMB) performs functions associated with operating, maintaining, and repairing medical and research facilities. In addition to these functions, a FMB may also perform a wide range of additional responsibilities to include administration of housekeeping, safety, physical security, transportation, and medical equipment programs. This document will not address the staffing or organizational requirements for these additional responsibilities. The organizational elements of a facility management branch can be divided into the following:

(1) Management/administrative.
(2) Engineering/technical support.
(3) Operations and maintenance (O&M).
(4) Contract administration/quality assurance.

c. The management/administrative element coordinates the planning, organizing, staffing, directing, and control of all facilities support. This element typically consists of a Chief, Facility Management Branch, and a clerk/typist. Typical functions for this activity include:

(1) Coordination of planning, organizing, staffing, directing, and controlling facility activities.
(2) Serving on key committees and boards.
(3) Administrative approval of projects and programs.
(4) Oversight of financial programs and budgets.

(5) Insuring that facilities meet all applicable requirements for accreditation.

(6) Establishing and maintaining liaison with the U.S. Army Installation Director of Public Works (DPW).

(7) Personnel administration and training.

d. The engineering/technical support element provides design and engineering services, programming of major construction, space utilization/space management, and technical support. This element usually consists of an engineer, preferably with electrical or mechanical background, and an engineering technician. The Chief, FMB, may assume the responsibilities of this organizational element. Typical functions for this activity include:

(1) Manage, track, and monitor engineering work requests, execution, closeout, and warranty issues.

(2) Energy management, and monitoring and control systems.

(3) Implementation of automated data support (ADP) systems for maintenance, financial, and project management.

(4) Consulting engineering studies and services.

(5) Facility master planning.

(6) Planning and estimating work.

(7) Management of all major repairs: A portion of sustainment and restoration and modernization projects.

(8) Space utilization/space management.

(9) Project scope development, and design.

10) Coordination on the design and execution of military construction (MCA) projects.

(11) Management of facility as-built plans.

e. The operations and maintenance support element manages maintenance and repair to buildings and structures, and supply and storage of tools and spare parts. This administrative portion of this element typically consists of an engineer with experience in facility maintenance, and an engineering support clerk who is responsible for maintaining job order logs, data entry into DMLSS-FM, maintenance of a facility library, and general clerk/typist. The wage grade element varies widely depending on whether maintenance is performed in-house or under contract. As a minimum, it is recommended that a small team of maintenance workers be assigned directly to the FMB to handle minor maintenance and repairs. Typical functions for this activity include:

(1) Operation and maintenance of utility plants and systems.

(2) Storage and maintenance of spare parts, materials, and supplies.

(3) Maintain an up-to-date equipment inventory.

(4) Coordination of work planning and programming activities.

(5) Cyclical inspections to systematically identify maintenance and repair requirements.

(6) Maintain all critical system records, test reports, and emergency procedure plans.

(7) Develop and maintain a maintenance program.

(8) Coordinate maintenance-training activities.

f. The contract administration/quality assurance element manages contract activities associated with facilities maintenance and engineering, financial planning,

programming, budgeting, execution, accounting, and review. This element typically consists of a contract specialist or resource management analyst, and a facility quality assurance evaluator (QAE) who is usually an engineering technician with experience in facility maintenance. The Chief, FMB, may assume the contractual and financial duties. Typical functions for this activity include:

(1) Management of applicable sections of Inter-Service Support Agreements (ISSA) and Memorandum of Agreements (MOA) with support agencies, such as DPW.

(2) Financial oversight of reimbursable accounts.

(3) Administration of contracts within delegated authorities, including conduct of quality assurance, surveillance/evaluation of contractor performance.

(4) Prepare reports required by higher headquarters.

g. Job Qualifications/Job Descriptions: Facility Manager qualifications should be one of the following:

(1) Be a registered professional engineer or licensed architect with experience in facility engineering and maintenance in healthcare or research facilities, as applicable. Strong electrical or mechanical background is preferred. The FM must have an in-depth knowledge of and basic experience in facility engineering and maintenance with emphasis on the unique nature and requirements of complex healthcare and research institutions. The FM must possess strong managerial and personnel skills.

(2) Have an advanced degree in business management with experience in facility engineering and maintenance in healthcare or research facilities, as applicable. The FM must have an in-depth knowledge of and basic experience in facility engineering and maintenance with emphasis on the unique nature and requirements of complex healthcare and research institutions. The FM must possess strong managerial and personnel skills.

(3) Have equivalent experience with at least two years experience in facility engineering and maintenance in healthcare or research facilities, as applicable. The FM must possess strong managerial and personnel skills.

(4) Job Descriptions: Refer to the U.S. Army Health Facility Planning Agency, Operation and Maintenance Management Plan (OMMP), Section 8, Staffing Guide, for typical job descriptions for:

- Facility Manager
- Secretary/Word Processor
- Project Engineer
- Facilities Maintenance Specialist
- Quality Assurance Evaluator

- Engineering Technician/CADD Operator
- Trades Coordinator
- Administrative Specialist
- Clerk/Word Processor
- Analyst/Industrial Engineer

- Planner Estimator/Scheduler
- Dispatcher/Clerk
- Materials Control Specialists
- Supervisor, Mechanical Branch
- Mechanical branch Leader

- Utility Systems Repairer-Operator
- Maintenance Mechanic Worker
- Air Conditioning Equipment Mechanic
- Maintenance Mechanic - HVAC
- Mechanical

- Plumber/Pipefitter
- Electrical and Electronic Branch Leader
- Electronic Industrial Controls Mechanic
- Electrician
- Electrician (High Voltage)

- Electrical Worker
- Supervisor, Building Structures Branch
- Building Structures Branch Leader
- Mason
- Painter

- Mason/Painter
- Sheet Metal Mechanic
- Carpenter/Locksmith
- Laborer
- Tools and Parts Attendant

h. Staffing Guidelines:

(1) Actual staffing requirements fluctuate based on the needs of the facility, and depend largely on the extent that maintenance is outsourced or contracted out. MEDCOM Logistics (ACSLOG) is currently developing an template that will be used by the manpower community to identify requirements. However, the following data listed below will generate the necessary detail to further strengthen any requirements that are not identified in the template.

(2) Staffing requirements for O&M type work can be accurately based on calculations related to PM effort. The number of support personnel (non-O&M) is often based on the number of O&M personnel. Staffing for trade supervisors are based on the total number of tradesman that are required. Once staffing requirements have been determined, they can be benchmarked against industry wide standards. See paragraph 8-33, page 8-42, in this chapter.

(3) To determine staffing requirements, an availability factor must be derived. The availability factor is used to determine the actual man-hours that can be applied to O&M work once training, sick leave, vacation time, holidays, and discretionary time is accounted for.

(4) Non-O&M staffing requirements can be based on roughly 15% of total PM requirements. Refer to OMMP, Section 8, for a typical staffing organizational diagram. Staffing organizational arrangements will vary widely depending on the specific needs of the activity.

8-18. FACILITY OPERATIONS AND MAINTENANCE

a. Definition: Operations and maintenance is the cycle of on-going, routine repair, alteration, maintenance and operation of the facility. Operating and maintaining health care and research facilities and associated common use areas is the responsibility of the facility manager.

(1) Reliability centered maintenance (RCM) is the integration of reactive maintenance (run-to-failure or breakdown maintenance), preventive (interval based) maintenance, PT&I (condition based), and proactive maintenance. RCM applies these four techniques in combination where each is most appropriate based upon the consequences of equipment failure and its impact upon organization mission, safety, environment, and Life Cycle Cost (LCC). This combination produces the required reliability at the minimum maintenance cost. The RCM philosophy employs reactive, preventive, predictive, and proactive maintenance techniques in an integrated manner to increase the probability that a machine or component will function in the required manner over an extended life cycle with a minimum of maintenance. RCM requires that maintenance decisions be based on maintenance requirements supported by sound technical and economic justification.

(2) Preventive maintenance (PM) consists of regularly scheduled inspection, adjustments, cleaning, lubrication, parts replacement, calibration, and repair of components and equipment. PM is also referred to as time-driven or interval-based maintenance. It is performed without regard to equipment condition. PM schedules periodic inspection and maintenance at pre-defined intervals (time, operating hours, or cycles) in an attempt to reduce equipment failures for susceptible equipment. Depending on the intervals set, PM can result in a significant increase in inspections and routine maintenance; however, it should also reduce the frequency and seriousness of unplanned machine failures for components with defined, age-related wear patterns. Traditional PM is keyed to failure rates and times between failures. It assumes that these variables can be determined statistically, and therefore one can replace a part due for failure before it fails. The availability of statistical failure information tends to lead to fixed schedules for the overhaul of equipment or the replacement of parts subject to wear. PM is based on the assumption that the overhaul of machinery by disassembly and replacement of worn parts restores the machine to a like-new condition with no harmful effects.

(a) A routine maintenance plan is required on all major pieces of equipment. The plan shall provide procedures with detailed maintenance tasks and associated frequencies. It shall also include a master schedule indicating when maintenance tasks should be performed, so that work is spread evenly throughout the year.

(b) Detailed PM procedures should include the time standard for each procedure (O&M manuals, manufacturers data, etc.), assignment of crafts or shops to each PM procedure, assignment of tools and materials to each PM procedure, and special notes and warnings. Refer to OMMP, Section 2, for typical routine

maintenance procedures. The procedures are not exhaustive, and the facility manager should reference a number of different sources to develop a complete set of maintenance procedures. Maintenance procedures should be customized for the specific facility.

(3) Predictive Testing and Inspection (PT&I), also known as predictive maintenance or condition monitoring, uses primarily non-intrusive testing techniques, visual inspection, and performance data to assess machinery condition. It replaces arbitrarily timed maintenance tasks with maintenance that is scheduled only when warranted by equipment condition. Continuing analysis of equipment condition-monitoring data allows planning and scheduling of maintenance or repairs in advance of catastrophic and functional failure. The PT&I data collected is used in one of following ways to determine the condition of the equipment and identify the precursors of failure. PT&I does not lend itself to all types of equipment or possible failure modes and therefore should not be the sole type of maintenance practiced. The methods of analysis include:

- Trend analysis
- Pattern recognition
- Data comparison
- Tests against limits and ranges
- Correlation of multiple technologies
- Statistical process analysis

b. Maintenance Records and Documentation: The facility manager shall be responsible for maintaining the following maintenance records and documentation. This does not preclude any additional documentation required for regulatory compliance.

(1) General facility information: Describe the function of the facility. Detail the overall dimensions of the facility, number of floors, foundation type, expected number of occupants, and facility category code.

(2) Site and floor plans: Provide legible site and floor plans. Floor plans shall only include room numbers, types of spaces, and overall facility dimensions.

(3) Utility connection/Cutoff plans: Provide site and floor plans that indicate the main interior and exterior connection and cutoff points of all utilities. Plans shall contain enough information to enable someone unfamiliar with the facility to locate the connection/cutoff points. The plans shall indicate the room number, panel number, circuit breaker, valve number, etc., of each connection/cutoff point; as well as which system, portion of system, or area that connection/cutoff point controls. These plans are physically distinct from site and floor plans discussed above.

(4) Warranty information: List each piece of equipment furnished by the construction contract and provide a cross reference to the written warranties. The equipment list shall indicate the duration of the warranty, start and end date of warranty, and point of contact for fulfillment of the warranty. Also list all maintenance required by the government to keep the warranty valid.

(5) Equipment inventory: Provide an equipment inventory in hierarchical format as shown in OMMP, Section 1.

(6) Training requirements: Provide a list of recommended training related to operation and maintenance of each installed system including training which is available from the manufacturer or other source. Refer to OMMP, Section 7, for a list of training requirements for O&M.

(7) As-Built Drawing List: Provide a list of as-built drawings. Include drawing number and title, and indicate where the drawings and specifications are physically located.

(8) System description: Provide a detailed description of system composition and operation. Descriptive matter and theory shall include technical details that are essential for understanding the system.

(9) Start-up and shutdown procedures: Provide step-by-step instructions to bring systems from static to operational status and from operating to shutdown status.

(10) Normal operating instructions: Provide discussion of the normal operation and control of the system. Include operating norms i.e., temperatures, pressures, and flow rates expected to each zone and phase of the system. The information shall be supplemented with control/wiring diagrams and data.

(11) System flow diagram: Provide an isometric flow diagram indicating system liquid, air or gas flow during normal operations.

(12) Emergency operating procedures: Provide emergency procedures for equipment malfunctions and shutdown instructions for fire, explosion, spills, or any other contingency.

(13) Environmental considerations: Provide a listing of systems/equipment which require special environmental consideration, reporting, testing, analysis, or inspection to comply with Federal and related state/local environmental laws. Examples are backflow preventor inspections, underground storage tank testing, etc.

(14) Safety instructions: Provide a list of all personnel hazards and equipment safety precautions including recommended safeguards.

(15) Provide a list of all major valves associated the system including valve type, number, function, and location.

(16) Routine maintenance plans and schedule: Provide a routine maintenance plan using manufacturers recommendations and sound engineering practice. The plan should cover all major piece of equipment.

c. Computer Aided Design (CAD): It is recommended that CAD systems, or other automated techniques, be employed to maintain as-built drawings, and other records and documentation. If a CAD system is used, the DMLSS Center of Expertise (DMLSS CTX) can assist with maintenance of these documents.

d. Computerized Maintenance Management Systems: It is the objective of MEDCOM to employ DMLSS-FM in all facilities. Typically, the CMMS provides for storage and tracking of work orders, routine maintenance, labor information, inventory, and equipment information. This section provides guidelines to assist facility managers in determining the division of work between in-house personnel and contractors. Implementation of DMLSS-FM at a medical or research facility will result in a number of benefits which include reduced equipment downtime, better organization and access of information for accreditation inspections, such as JCAHO, CAP, and AAALAC, improved inventory management, increased labor efficiency, identification of chronic equipment malfunctions, centralized maintenance data, extended equipment life, and reduced maintenance costs.

(1) Requirements of DMLSS-FM can be subdivided into those necessary to support accreditation inspections, those required specifically at Army facilities, and those related to data reliability, security, user interface, and information transferal and exchange.

(2) Proper organization of utility systems data and reporting methodology are essential in supporting documentation for accreditation. Below is a list of reports that DMLSS-FM should include to meet this need:

- A report listing all components and characteristics of utility systems.
- A report detailing all work orders performed on critical systems, such as the emergency power system.
- A work order summary report that includes description of problems, responses and associated response dates, and the name of the individual responding.
- A report demonstrating trends of equipment failures, and how these failures are addressed.
- A report summarizing the total work order history for the preventive maintenance program.

(3) Successful implementation of DMLSS-FM is to a large extent determined by the following factors:

(a) Accurate and up-to-date data collection on equipment, spare parts/materials, vendors, contractors, and personnel.

(b) On-site training of users and managers. A minimum of 24 hours of input training and 16 hours of output training should be provided.

(c) System commissioning under operating conditions by creating sample work orders, printing sample reports, etc. The software vendor should provide at least 40 hours of system commissioning.

f. Maintenance Contracts: Maintenance contracts are essential elements of a well-rounded facility management program. In most cases, the complexity of modern building equipment makes it unfeasible for maintenance personnel to handle all aspects of building maintenance. Many types of equipment require maintenance to be performed by specially trained personnel. OMMP, Section 3, Table 3-1, lists systems that are advantageous to perform under maintenance contract. Maintenance contracts can be administered as individual service contracts or as

comprehensive facility wide contracts. Typically, facility wide maintenance contracts include routine and unscheduled maintenance, with provisions for repairs, and minor construction.

(1) When analyzing maintenance contracts, specific attention should be given to:

- Contractor's qualifications
- Experience:
  - Quality of services
  - Personnel qualifications
  - Methods of documentation
  - Management expertise
- Contract Type and Coverage
- Routine Maintenance Program
- Capability to perform minor and major repairs
- Capability to respond to emergency repairs
- Length of contract with year options
- Terms of contract:
  - Billing procedures
  - Contract cancellation rights
  - Itemization of invoices
  - Warranty monitoring
  - Liability
  - Insurance
- Contract cost:
  - Standard and overtime wages
  - Spare parts costs and markup
  - Travel costs
  - Price per service call
- Quality Assurance Program

(2) Contract Type: It is the responsibility of the FM to perform an analysis to determine the most cost effective type of contract to be used. Ultimately, the cost of the contract must be within the funding level provided by higher headquarters. Contract type is varied, but the following are often used on building maintenance:

(a) Fixed Firm Price: A firm-fixed-price contract provides for a price that is not subject to any adjustment on the basis of the contractor's cost experience in performing the contract. This contract type places upon the contractor maximum risk and full responsibility for all costs and resulting profit or loss. It provides maximum incentive for the contractor to control costs and perform effectively and imposes a minimum administrative burden upon the contracting parties. This style contract can be expensive if there is no historical work load data from which a contractor can base his bid/staffing and is subject to modifications for any change in requirements.

(b) Cost Plus Award Fee: This is a performance-based contract in which the contractor is compensated for allowable reimbursable cost. Additionally, the contractor may receive both a base fee that does not vary with performance and an award fee that is determined by an evaluation of the contractor's performance. The reimbursable cost is based on a nominal markup, so it is to the contractor's advantage to perform well and receive the award fee.

(c) Combination Fixed Firm Price/Cost Plus: Typically, under this style contract, routine maintenance is performed as a fixed price, and unscheduled maintenance is performed on a cost plus basis.

(3) Major Repairs/Minor Construction (MR/MC): Provisions for minor construction and major repairs should be included as part of a facility maintenance contract. The level of participation by the maintenance contractor in MR/MC should be evaluated in terms of the capability of the FM to perform MR/MC through JOC, and DPW.

(4) Division of Work: Maintenance work is often divided into levels depending on the response time and work priority. Work that is not classified as routine preventive maintenance is considered demand maintenance. Each work order is assigned a priority to distinguish the most urgent response requirements from those that require less immediate response. The work order priorities are assigned on the basis of a particular piece of equipment. Each major piece of equipment will typically have a response priority assigned to it. The priority categories are as follows:

(a) Priority 1, EMERGENCY: This is work that is required to correct an emergency condition detrimental to the facility mission or that endangers the health and welfare of the staff and patient and reduces the operational effectiveness. Corrective action for emergency work should start immediately and continue until completed.

(b) Priority 2, URGENT: This is work to correct an unsafe condition that is not an immediate hazard to personnel, but must be initiated within the shift and completed within 5 working days.

(c) Priority 3, ROUTINE: This is work to improve the operation of the facility that can be completed within 30 working days.

(d) Priority 4, SCHEDULED: This is work that is not one of the above and can be accomplished within 120 days.

8-19. PROJECT MANAGEMENT

a. General: Project management consists of planning, programming, budgeting, and executing sustainment, restoration and modernization projects. This section applies to major repairs for projects over $25,000. Projects that are under $25,000 are considered minor repairs. Minor repairs are managed as part of the activity's recurring maintenance and minor repair program (i.e., R-Line distribution).

b. Minor Construction: Reference 10 U.S.C. Section 2811 (Public Law 104-106), AR 420-10, *Management of Installation Directorates of Engineering and Housing*, 2 Jul 87, and AR 415-15, *Army Military Construction Program Development and Execution*, 30 Aug 94. The threshold for minor construction projects is $750,000.

c. Life, Health, or Safety: A special threshold for minor construction projects to correct life, health, or safety deficiencies became effective with Section 2811 of

Public Law 104-106. Effective with the President signing the FY96 Defense Authorization Act on 10 Feb 96, Section 2811 of Public Law 104-106 provides special threshold for unspecified minor construction projects to correct life, health, or safety deficiencies. The new limits are not retroactive. The new limits are as follows:

(1) The minor MCA subsection of the Law adds the following: "However, if the military construction project is intended solely to correct a deficiency that is life-threatening, health-threatening, or safety-threatening, a minor military construction project may have an approved cost equal to or less than $3,000,000."

(2) The O&M section of the Law is changed to the following:

"(A) $1,000,000, in case of an unspecified military construction project intended solely to correct a deficiency that is life-threatening, health-threatening, or Safety threatening; or
(B) $500,000, in the case of any other unspecified military construction project."

(a) MACOM Commanders can approve the new O&M limit or delegate it to their installations (Note: Approval authorities may change under the Installation Management Activity (IMA) transition in Oct 02). Delegation of approval authority is to be in writing. The new special threshold does not change any other approval limits or work classification requirements. The local DPW maintains the responsibility for work classification. However, it is the responsibility of the Facility Manager to justify deficiencies that are questioned by the DPW. ACSIE&FM will assist the MTF in stating the life-threatening, health-threatening, or safety-threatening deficiencies and endorse the need for valid projects. Unspecified minor construction (UMC) projects will be submitted to:

Health Facility Planning Agency (HFPA)
5109 Leesburg Pike, Suite 679
Fall Church VA 22041-3258

UMC projects must be accomplished with photos, clear description of the project requirements, and justification identifying the life-threatening, health-threatening, or safety-threatening deficiencies.

d. MEDCOM Approval Process: Any major repair project must be submitted on a MEDCOM Form 234-R (MCFA). This form must be completed with all the necessary coordination and signatures. All projects will be submitted to the MSC for validation, approval and regional prioritization. Upon approval, the MSC will prioritize and fund the project based on funds available and if it is within specified funding range. Currently, this range is $25,000 to $300,000. Projects greater than $300,000 will be forwarded by the MSC directly to ACSIE&FM for approval. The ACSIE&FM will release funds for approved projects. Projects will be funded in accordance with the MEDCOM prioritizing scheme and the MTFs ability to execute.

e. Medical Facility Support Program

(1) General: The Medical Facility Support Program allows FMs and MEDCOM DPWs access to a number of innovative and cost-effective operations, maintenance, repair, minor construction contracts as well as a variety of facility-related services. The compilation of these contracts is called “toolbox”. Toolbox

contracts are in place at selected contracting activities called "Medical Support Teams" (MSTs) that meet the regulatory requirements under the Economy Act and Intra-DoD Offloading. The USAMEDCOM and has established MOUs with MSTs. This allows MTFs to obtain operations and maintenance and other support services on a timely and cost effective basis. The DPW must be offered reimbursable projects prior to obtaining the services from alternate sources. Toolbox allows the FM and DPW a way to accomplish mission requirements. The MEDCOM TOOLBOX manual provides guidance on planning, executing, and administering work within the Medical Facility Support Program. Types of contracts included in TOOLBOX are:

- Major Repairs/Minor Construction
- Fire Protection Services
- Energy Audits
- Operational & Maintenance Engineering Enhancement
- A/E Services

- Preventive Maintenance/Equipment Inventory
- Facility Assessments
- Duct Cleaning & Repair
- Electrical Testing
- Renovation and Minor Construction
- Modular Buildings
- Asbestos Abatement

- Interior Finishes
- Interim Operation & Maintenance Services
- Interior Design/Master Planning
- Medical Job Order Contracting
- Boiler Inspection Services

- Medical Gas Testing & Environmental Monitoring
- Environmental Monitoring and Analysis
- Project Support Services
- Signage Systems (System 2/90)
- Energy Savings Performance Contracts

- Plant Management and Fire Alarm Systems
- Integrated Medical Modular Support System (IMMSS)
- Operation and Maintenance Contracts
- Environmental Compliance Contract
- Lead Based Paint Testing/Assessment/Mitigation

(2) Responsibilities. As of Oct 1997, HFPA has the responsibility for management of project support services and the toolbox program. HFPA will:

(a) Identify MSTs to provide the acquisition and engineering/technical support for toolbox and negotiate MOUs.

(b) Identify and provide scopes of work to MSTs for those services that are required by FMs support operations and maintenance.

(c) Issue and maintain the toolbox manual.

(d) Provide technical assistance to the FMs using project integrators.

(e) Provide review and prioritization of projects for submittal to the MEDCOM SRB.

(f) Coordinate COR duties in support of the contracting officer.
(g) Provide technical assistance to FMs in preparation of development of work plans and cost estimates.
(h) Review request for contract services form FMs and forward to PSA.

(3) FM - Toolbox Responsibilities: FMs will:

(a) Develop internal procedures for implementation of toolbox contracts.
(b) Establish working agreements wit the Directorate of public Works (DPW) and other host installation support activities for processing work requests and obtaining approval for reimbursable projects.
(c) Identify to HFPA any additional services desired for inclusion into toolbox.
(d) Insure the complete requests for services packages are prepared for processing through the MSTs.
(e) Maintain a file of each delivery order issued by the PSA for the activity.
(f) Provide required level contract management of each project.
(g) Provide the PSA a receiving report or completion of services statement, as required.

(4) DPW Interface: For toolbox contracts to effectively work, it is essential that the FM thoroughly coordinate with the DPW. The DPW must:

(a) Receive requirements for the FM.
(b) Return approval to the FM with a signed work request, DA 4283.
(c) Accomplish work by:

(1) In-house work forces or other pre-established contracts
(2) Competitive bid
(3) Accomplish work using toolbox contracts

f. Work Plans: Work plans are an alternative means of project execution in lieu of the lengthy process of full-scale project design and execution. The contractor generates a work plan for the project based on a site visit and a written scope of work. This work plan is provided to the FM for review and comments. The FM must obtain all local reviews and coordinate the return of all comments. The work plan includes these items. Some of these can be waived on small and uncomplicated projects.

(1) Executive summary providing a brief description of the work.
(2) Narrative description of work required, referencing study and design calculations.
(3) Sequential listing of steps required for the project execution.
(4) Work schedule
(5) Drawings, as applicable
(6) Standards and engineering specifications
(7) Engineering calculations and analysis
(8) Scope of work
(9) Material take-offs

(10) Catalog cuts and equipment specifications
(11) Manufactures and installation procedures or execution specifications
(12) Outline of training
(13) Outline of O&M documentation
(14) Video of site

g. Work Plan Coordination: Reviews and coordination of these work plans and/or design must be efficiently accomplished in order for toolbox major repair and minor construction projects to. This reduces the need for costly modifications and delays during the construction phase. All functional areas should be involved in the reviews. Reviewers will screen proposed work plan for conflicts and/or omissions within their functional area. They should provide written comments within the suspense time set for the review by the Facility Manager. The Facility Manager will compile and forward comments to the appropriate Corps of Engineers District. The work plans should be reviewed in the following functional areas as applicable to the size and type of project:

FUNCTIONAL AREA	REVIEW AGENCY
Functional Use	MTF End User
Facility O&M	Facility Manager
Physical Security	Phys Sec Br/ PMO
Information Systems	Info Mgmt Office
Environmental Health	Occupational Health
Safety	Safety Office
Fire Safety	DPW
Environmental Assessment	DPW
Historical Compliance	DPW
Utility System Standards	DPW
Mechanical System Standards	DPW
Technical Engineering Criteria	DPW
Installation Design Guide	DPW

8-20. FINANCIAL MANAGEMENT

Financial accounts are important to the operation and maintenance of a facility.

a. Two types of financial accounts primarily concern the FM. Base operations are funded with O&M funds. Baseops is generally discussed in two broad categories; SRM and Baseops(-). Within the broad category of Baseops(-), one of its sub-categories (program elements) is called Real Property Services (RPS). FMs are concerned with SRM and RPS.

(1) Sustainment, Restoration and Modernization (SRM). For an explanation of SRM funds usage, refer to para 8-16 of this chapter.

(2) Real Property Services

(a) Operation of utilities: Operating the utility plants and distribution systems and purchased utilities.

(b) Municipal Services, Facilities Engineering Services, and Fire & Emergency Response Services. Providing fire protection, refuse collection and disposal, pest management, custodial, packing and crating, installation of equipment, and other engineer related services such as preparation of contract plans and specifications, contract inspection, master planning, construction programming, and real property and real estate management.

b. The Assistant Secretary Of Defense For Health Affairs ASD (HA) is the sole DoD official for the effective execution of the department's medical mission. Medical facilities and funding are subject to the authority, direction and control of the ASD (HA).

c. Funding Obligations: Reference DFAS-In manual 37-100-xx. OMD funds are to be used for all maintenance of category 500 buildings as well as any minor repair for category 500 buildings less than $25,000. All new work less than $25,000 will be charged to the activity mission core funds.

d. Program Objective Memorandum (POM): The program document portraying estimated obligations for the five program years. This document is constructed by HQ MEDCOM personnel.

e. Budget Estimate Submission (BES): A budget document portraying estimated obligations for the current (next year) and budget year (following current year).

f. Prior Year Funding: Projects awarded but not completed in the same year may require prior year dollars for within scope modifications. Send requests for prior year funds to your local resource manager. If funds are available, your resource manager will use the documentation to fund the increase. If funds are not available locally, forward the request by e-mail to ACSIE&FM. Contact ACSIE&FMACSIE&FM for the current format.

8-21. SUPPORT AGREEMENTS

a. Inter-Service Support Agreements (ISSA): The FM should reference DD Form 1144 and AR 5-8. The ISSA designates a supplying and receiving activity, and governs services required from the providing agency to the receiving agency. As such, resource managers and Commanders or their designated representatives usually sign it. The proponent for the ISSA is Resource Management. For each support category, a basis for reimbursement and estimated reimbursement amount are provided. Support categories that are usually related to facility management functions are:

- Common Use Facility Operations, Maintenance, Repair and Construction
- Facility Maintenance and Repair of Real Property and Space Management
- Utilities

(2) The FM should consider the following when developing a draft MOA or reviewing a finalized ISSA:

- Standard Level of Service (Includes compliance standards, such as JCAHO, response times, quality assurance)
- Quantity
- Frequency
- Basis for Reimbursement (Includes basis of payment, method of payment transfer, rate scheme)

(3) Basis for reimbursement can be complicated when installation facility support services are supplemented with contract support services. The FM is responsible for working with the RM and the supplying agency, in most cases the DPW, on development of a basis of reimbursement that offers the greatest economy, efficiency, and flexibility. Costs, such as annual fees, special service rates, and internal and external overhead, may be immediately apparent from the ISSA reimbursement schedule.

(4) A clause should be included giving the receiving agency, such as the MTF, the authority to us an alternate supplier, such as an outside contractor, if the supplier cannot meet the conditions stipulated in the ISSA. This is commonly referred to as right of first refusal.

8-22. REGULATORY CONTROLS AND ACCREDITATION

The Joint Commission of Health Care Organizations (JCAHO) accredits Health Care Facilities. The Accreditation Manual for Hospitals (AMH) provides compliance standards for facilities under the Management of the Environment of Care section. The goal of this section is to provide a safe, functional, and effective environment for patients, staff members, and other individuals in the hospital.

a. Management of environment of care functions consist of:

- Design (Program needs assessment)
- Teaching (Knowledge needs assessment)
- Implementation (Routine work/failure correction)
- Measurement and Assessment (Management of information standards and program performance assessment)
- Improvement (Improving organizational performance standards and improvement assessment)

b. General areas addressed in the management of the environment of care are:

- Safety
- Security
- Hazardous Materials and Waste
- Emergency Preparedness
- Life Safety
- Medical Equipment
- Utility Systems
- Social Environment

c. FM Responsibility: The FM shall be responsible for insuring that buildings, which house patients or in which patients receive treatment are in compliance with the Life Safety Code (LSC), NFPA 101, and those systems, such as essential electrical distribution, are in compliance with NFPA 99. Compliance with NFPA 101 is maintained by performing a Statement of Conditions (a LSC survey) on all facilities required by JCAHO, and follow up with a Plan for Improvement (PFI). The PFI lists all associated projects, project milestones, and costs.

(1) Performance Plans: The FM shall be responsible for the development of a utility management performance plan and coordination of pertinent sections of all other required performance plans. It covers:

- FM Responsibilities, Organization, & Staffing
- Systems Overview and description
- Facility Training program and requirements
- Critical Systems List and inventory
- Maintenance procedures
- Emergency preparedness procedures
- Testing Requirements
- Performance Indicators

d. Scoring: AMH, Volume II, gives scoring guidelines for the Management of Environment of Care standards.

e. Research Facilities: The Council of American Pathologists (CAP) and the American Association accredit research facilities for Accreditation of Laboratory Animal Care (AAALAC). Facilities maintaining, using, importing, or breeding laboratory animals for scientific purposes seek AAALAC accreditation. AAALAC accreditation is based on standards established in the Guide for the Care and Use of laboratory Animals, which is published, by the U.S. Department Of Health and Human Resources, National Institute of Health. Animal care facilities are visited at intervals of three years or less.

8-23. ENVIRONMENTAL MANAGEMENT

a. General: Refer to AR 200-1 and AR 200-2. Within the context of the facility manager’s organizational span of control, the facility manager, the Chief of Logistics, the Safety officer, and the Environmental Science officer (ESO) are the primary personnel responsible for environmental compliance in MEDCOM facilities. Environmental compliance at the installation is the responsibility of the installation Environmental Division who often is part of the Directorate of Public Works. All regulatory issues should be coordinated through the ESO. The ESO performs the following functions:

(1) The ESO routinely convenes staff meetings to review the status of environmental compliance projects and any new requirements that may have arisen. The ESO should include officers from the various facilities' directorates. Typical attendees should include the following: Infection Control Nurse, Dentist, Doctor, Safety, Facility Manager, DOL/Chief of Services, house cleaning, etc.

(2) The ESO gathers the information provided during the staff meetings and compiles the facility's environmental requirements into the A106, Environmental

Program Requirements (EPR) Report. It is an automated report that can be used as a tool to obtain funding for bona fide environmental projects. This program is managed by the medical facility's ESO who submits a biannual environmental report detailing the facility's requirements and funding status of projects. The following are typical environmental projects that could qualify for special environmental funding through the A106 process:

- RCRA
- Hazardous Waste:
  Surveys/Sampling/Analysis/Disposal
- Training
- HazMin Plans/Pollution Prevention/Solvent Recycling
- UST:
  Upgrades/Sampling/Removals/Permitting/ Tightness Testing

- Regulated Medical Waste Management
- Silver Recovery/Filmless X-ray Equipment
- Decommissioning Studies/Cleanup
- CWA/SDWA
- Obtain Discharge Permits & Fees

- Surveys, Sampling & Analysis (Lead & Copper, Biomonitoring)
- Construction Projects for Point Source Modifications
- Pretreatment Requirements/Stormwater Discharge Program
- Spill Response and Contingency Plans
- Cross Connection/Backflow Preventors

- Storm water Discharge Monitoring
- TSCA
- Asbestos Surveys/Plans/Limited Removal
- Lead Based Paint Surveys/Plans/Limited Removal
- PCB Surveys/Plans/Removal

- CAA
- Air Emission Inventories & Updates
- Air Operating Permits
- Implement CFC/Halon Reduction Program
- Pay Annual Permit Fees

- Perform Monitoring & Testing (ETO)
- Asbestos surveys/Assessments/Plans
- Radon Testing and Surveys
- Upgrade Pollutant Control Systems
- Incinerators/Training/Replacement

- NEPA
- Environmental Baseline Studies
- Environmental Assessments/Environmental Impact Statements

b. Environmental Compliance on Projects: It is the facility manager’s responsibility to make sure that scope of all major repair projects include environmental abatement, such as asbestos, lead paint, etc. where required. If not sure of the extent of environmental mitigation, the facility manager should have test performed for verification.

c. Asbestos: SRM projects often encounter asbestos during execution. This often causes costly project delays. In many cases, asbestos is not discovered during design. Every project must include a plan that will enable prompt abatement in the event that asbestos is discovered during execution. Ensure the following areas are thoroughly looked at on your projects before execution. These are hiding places for asbestos that are often overlooked during design and work plan development:

- Lay-in ceilings may conceal older plaster ceilings, containing or concealing asbestos
- Behind finished walls and blocked windows from previous renovations
- Inside chases and walls
- Old transit water piping and ducting
- Behind metal housing of radiators

- Roof felts and mastics
- Below windowsills
- Water and sewer lines including abandoned lines
- Electrical conduit installation
- Crawl spaces

- Floor tiles and mastic including tiles covered by walls and casework (note that many projects do not have tile work in the scope, but floor tile often end up being disturbed or destroyed).
- Carpets and adhesives adhered to older VAT floor tiles
- Contaminated soil in crawl spaces from previous renovations
- Exterior insulated metal wall panels
- Around underground fuel tanks
- Steam trench cover insulation

Installation Directorates of Public Works often have a requirements contract that can be activated quickly to remediate asbestos.

d. Recycling: In accordance with Executive Order (E.O. 12856) federal activities are required to reduce their solid waste (SW) stream by 50 percent by 1999 using 1994 as the base year. However, integrating and interpreting state requirements for proper waste classification is not an easy task. It is difficult to discuss regulated medical waste (RMW) with a given hospital since there are 42 different state definitions of RMW. Hospitals generate 1 percent of all municipal solid waste (MSW) in the USA. Hospital SW composition is generally: 15 percent RMW (also recommended maximum standard), 5 percent HW and 80 percent MSW. A five hundred-bed hospital averages 3.5 tons of waste per day. Eighty per cent of that tonnage is non-HW or non-RMW. The 80 percent of the MSW is further divided as follows:

- 45 percent paper/cardboard
- 15 percent Plastic
- 10 percent metal
- 10 percent food waste
- 7 percent glass
- 3 percent wood
- 10 percent other

(1) Source reduction opportunities include using the following reusable items: cloth under pads, gowns, linen bags, mailers, respiratory therapy equipment and packaging materials for RMW. Consider eliminating disposable egg crate mattress overlays by purchasing mattresses with built-in egg crates.

(2) There are constraints as to how revenue can be spent. Generally, the environmental office can use a maximum of 50 percent of the revenue and the balance must be used for morale welfare and recreation activities. Consult with your host installation environmental office for further guidance.

8-24. UTILITY MANAGEMENT

Utility management is the management of utilities (electrical, water, natural gas, etc.) necessary to maintain continuous operation of equipment and systems in a facility.

a. Central Plant Operation: Operation, maintenance, repair, and improvement of utility plants and systems, including water supply, electrical, heating and ventilation, refrigeration, fuel dispensing, and air conditioning systems is the responsibility of the facility manager.

b. Operator training: Operator training guidelines are given in the OMMP.

c. Permits: The facility manager shall be responsible for maintaining a consolidated list of operator permits in accordance with current statutory and regulatory requirements.

d. Plant Management Systems (PMS): It is recommended that utility systems be monitored and controlled through a PMS. It is recommended that the FM CTX (located at Madigan Army Medical Center) or the HFPA Project Integration Branch be contacted for guidance on PMS application.

8-25. ENERGY MANAGEMENT

a. General: Reference the *DoD Energy Managers Handbook. The Energy Policy Act of 1992* and Executive Order 12902 established the DoD mandate of reducing facility energy consumption 30% by 2005, compared to 1985 baseline levels. Executive Order 12123 increased that goal to a 35% reduction in 2010, compared to the 1985 baseline. These federal mandates also authorized alternative funding methods to finance costs associated with achieving the specified reductions.

b. ECIP: The Energy Conservation Investment Program (ECIP) is a DoD military construction funded program for projects over $500,000 for improving the energy efficiency of existing Army facilities or constructing new, high efficiency energy systems. ECIP projects do not compete for resources with Army MCA or OMA requirements. DAIM-FDF-UE conducts an annual call for ECIP project submissions in the spring of each year. DD 1391s for ECIP candidate projects should be sent to the command headquarters by May of each year, so that they can be forwarded for consideration. Information in the DD1391 must include the cover sheet and a current well-supported life cycle cost analysis (LCCA) summary sheet. All appropriate savings from energy efficiency, demand reduction, water conservation,

reduced maintenance or manpower requirements, and utility rebates should be included.

c. ESPC: The Energy Policy Act of 1992 authorized private sector funding to accomplish energy saving retrofits in Army facilities. The Energy Savings Performance Contract (ESPC) is a contracting methodology in which a private contractor, called an Energy Services Company (ESCO) performs services such as facility energy audits, installation, operation and maintenance of equipment, technical services, and similar work in "partnership" with the Army. ESPCs generally function as Indefinite Delivery/Indefinite Quantity contracts in which the contractor identifies energy improvements, performs the work at a fixed price, and secures financing to pay for the improvements. The Army then repays this loan from the realized energy savings. ESPC can be used for any work that results in a simple payback of 10 years or less. The actual loan term can extend up to 25 years. ESPCs provide facility managers with a solution to some of their facility problems, while minimizing their up-front costs. Retrofits offering a rapid payback can be leveraged so that their savings pay for other associated improvements to maintenance, reliability, or quality of life factors. An effective partnership also allows the Army to rely on the ESCO's technical expertise to design, improve, operate, and maintain energy related equipment, freeing up scarce engineering staff. Consideration must be given to the impact on future O & M work. If failed and failing conditions are corrected, the DPW may classify any future work as new work (vs. existing work).

8-26. SPACE MANAGEMENT AND UTILIZATION

a. General: Space management is the process of identifying and projecting space requirements, identifying deficiencies, allocating available space to users in an equitable way, monitoring use, assisting users with space usage problems, and resolving space problems. Space management also addresses quality of space. Space management functions in MEDCOM facilities may or may not be a direct responsibility of the facility manager. However, the facility manager is responsible for reducing the cost of maintenance, repair, and operation of facilities through better space utilization and conservation, and avoiding unnecessary new construction projects. Space management ensures each user is assigned the appropriate space. When an activity obtains excess space, waste of scarce and expensive resources occurs due to under utilization. Conversely, over utilization occurs when an organization occupies less space than actually authorized. The costs of incorrect utilization may be additional utilities and maintenance funds and potentially degraded performance of a unit that could be occupying more productive space.

b. Space Management Goal and Objectives: The space management goal of the AMEDD is straightforward and tasks commanders to use facilities in the most effective way for cost and mission accomplishment. Space is a resource that requires management. Failing to manage this resource can result in a loss of productivity and scarce funds. In support of the space management goal, the AMEDD has adopted the following objectives.

(1) Use existing facilities, property, and space in an efficient manner.
(2) Reduce the need to construct or otherwise acquire facilities by using existing facilities.

(3) Determine any shortfalls or excesses of assigned facilities and space consistent with activity mission.
(4) Eliminate uneconomical, high maintenance facilities.
(5) Take action to deal with shortfalls or excesses.
(6) Eliminate off-post leasing.
(7) Dispose of land, facilities, or space that is excess to our needs.

c. The successful attainment of our space management goal is dependent on the commander emphasis. The process to conduct space management and includes:

(1) Establishing a space utilization inventory by department or activity.
(2) Calculating space requirements by department or activity.
(3) Identifying space allocation deficiencies and excesses by department or activity.
(4) Developing and evaluating space management options.
(5) Implementing space management decisions.
(6) Establishing a space utilization committee that is chartered to manage all space utilization issues.

d. Funding Impact: In the past, new construction was often the answer to facility shortfalls. This is no longer the case. The amount of money allocated for Medical Military Construction (MILCON) funds is likely to continue dropping. Reduction of the Operation and Maintenance, Defense (OMD) funds is also occurring. The process to rectify facility excesses or shortfalls is contingent on the optimum use of existing facilities. Reduction of the Operation and Maintenance, Defense funding mandates optimum use of existing facilities.

e. MILCON Project Space Management: The MILCON replacement of a facility always draws auditors and high-level command interest and requires special emphasis. The cost-effective reuse/demolition of the old facility is always one of the major items of interest. It is mandatory to complete the following procedures at least 12 months prior to occupancy of the new facility. Once completed, update the process periodically until final disposition of the old facility occurs.

(1) Establish a space utilization inventory for new and existing facilities by department or activity. The space inventory already exists for new facility in the form of the Program for Design (PFD). The PFD is the space program that the architect used to design the new facility. The PFD identifies assigned personnel (included are the contract and partners if identified during the programming stage) and the room or space required by these personnel and their activities. If the MTF does not have an existing inventory of assigned space, the MTF must develop it. If a building is excess, determine only the buildings gross area. This will identify all known excess facilities and provide a departmental inventory of assigned space for all activities not included in the new facility.

(2) Calculate space requirements by department or activity. This requirement already exists in the PFD. The HFPA prepare the PFD to meet the Department of Defense (DoD) medical space planning criteria. The only activities not covered by the PFD should be as a result of new missions or activities purposely not included in the new construction. Calculate the space requirements for these

activities using the DoD Medical Space Planning Criteria (MSPC). This criteria exists in a personal computer (PC) based, automated format that is available from HFPA. The DoD MSPC is contingent upon optimal conditions at a medical center. Because of this, you may find that the criteria are above what your MTF actually requires. This will not be unusual especially at community hospitals. In those instances, use your professional and clinical common sense to establish a requirement that meets the needs of your activity. There should be few, if any, instances where the planning criterion does not provide sufficient space.

(3) Identify space allocation deficiencies and excesses by department or activity. This step is simply a comparison of the space inventory versus the space requirements. This will identify space deficiencies and excesses.

(4) Develop and evaluate space management options. There are basically three ways to satisfy space deficiencies.

(a) Consolidate into the best existing facilities. The activity must begin by evaluating existing facilities to determine if any remaining facilities can satisfy the space deficit. If renovation is necessary, compare the renovation cost to the cost of new construction and leasing. If renovation is the most cost-effective solution, the activity must consolidate into the best facilities. In no instance will a World War II wood building be acceptable as a medical facility. Vacate all World War II wood buildings as soon as possible and find other facility solutions to replace them.

(b) New construction, permanent, or temporary: If acceptable existing facilities are not available, take steps to initiate new construction projects. This can be done as a submission to our minor construction program (greater than $25K but less than $750K of new work); the Unspecified Minor Construction Program (greater than $750K but less than $1,500,000); or the construction is not possible in the required time, a temporary facility may be the interim solution. In all instances, an Economical Analysis of renovation versus new construction versus lease must be available.

(c) Lease. If leasing is a viable option, the Economical Analysis must prove that it is the most cost-effective solution.

(5) Excess space: Identify all excess buildings to the installation as excess to medical requirements. Do this only after coordination with our Director of Healthcare Operations and the Assistant Chief of Staff for Installations, Environment, and Facility Management. The DA medical requirements such as TOE hospital movement or mobilization requirements, not yet known by the MTF or the installation, may be available at MEDCOM headquarters. As per AR 40-2, *Army Medical Treatment Facilities General Administration*, paragraph 1-10b, the installation must formally obtain our approval prior to diversion, conversion, or demolition. MEDCOME will not fund the operation and maintenance of any facility/space that is excess.

f. Normal Space Management: This process follows the same five steps as MILCON space management without the complication of new construction.

(1) Establish a space utilization inventory.
(2) Calculate space requirements by activity.
(3) Identify space deficiencies and excesses.
(4) Develop space management options.
(5) Implement space management decisions.
(6) Manage space under the guidance and direction of a space utilization committee.

g. Conversions and Diversions:

(1) The DPW has the primary responsibility for management, acquisition, and disposal of real estate (DA Pamphlet 420-9). Conversions and diversions are spelled out in AR 405-70, paragraph 3-6. A conversion is a permanent change to a facility's design CATCODE. A diversion is a temporary change to a facility's current use CATCODE. Real property requirements for demolition and disposal are covered in AR 405-90.

(2) These actions are the responsibility of the real property specialist in the Directorate of Public Works (DPW). Conversions and diversions of facilities are defined in AR 405-70. Conversion and diversion of MTF require approval of the US MEDCOM.

(a) AR 405-70, paragraph 6-3.d. (10) states: "Diversion or conversion of facilities initially constructed or subsequently converted to a Medical Treatment Facility will not be converted or diverted without approval of the US Army Medical Command (USAMEDCOM) for United States based facilities, or the appropriate medical command if OCONUS. See AR 40-2, paragraph 1-10."

(b) AR 40-2, paragraph 1-10.b states: "Buildings initially constructed or subsequently converted to house MTF or AMEDD personnel will not be altered, modified, or diverted from their original use without prior authority of the USAMEDCOM. Authority for conversion without provision for reclaim in the event of a requirement will be granted by MEDCOM where no present or future medical requirement exists. Approval of the MEDCOM will also be obtained prior to making any major changes in the functional arrangement or layout of any part or portion of an MTF. MTF include hospitals, troop clinics, laboratories, dental and other clinics, and quarters specifically constructed for AMEDD personnel, including civilian personnel."

Note: MEDCOM or Major Subordinate Command approval of a major repair or minor construction project constitutes approval of a major change in the functional arrangement or layout of an MTF. Based on AR 405-70, paragraph 3-6.e, and AR 40-2, paragraph 1-10.b, requests for conversion require the following seven items:

- Facility number
- Existing design use CATCODE
- Proposed design use CATCODE
- Justification
- Date of proposed conversion
- Signature of the installation commander
- Approval from installation medical commander

(1) Based on AR 405-70, paragraph 3-6.e, and AR 40-2, paragraph 1-10.b, requests for diversion require the following eight items:

- Facility number
- Existing design use CATCODE
- Proposed current use CATCODE
- Justification
- Statement that the IFS-M and real property records will reflect the diversion
- Date of proposed diversion
- Signature of the installation commander
- Approval from installation medical commander

(2) Or the following three items:

- An unexecuted, but completed, DA Form 337
- Signature of the installation commander
- Approval from installation medical commander

h. Category Codes: Category codes (CATCODE) identify the facility class and the facility category group. Category codes for various types of facilities can be referenced in AR 40-2.

i. Demolition: The DPW real property specialist must get predisposal clearances for all hospital and medical facilities before they finalized the disposal and demolition of the MTF buildings. AR 405-90, paragraph 6-4.d. states: "The US Army Medical Command must concur in the disposal of hospitals and medical facilities under its control. (See AR 40-2) Disposal of such facilities not under the US Army Medical Command must have prior approval of the appropriate MACOM." Based on AR 405-90, paragraph 6-4.d., and AR 40-2, paragraph 1-10.b, requests for predisposal clearance of a MTF must include the following:

- Name of installation
- Facility number and installation number
- Gross square feet and UM2 of the facility
- Facility type (permanent, semi-permanent, & temporary)
- Design use and current use CATCODE
- Original cost and year built
- Justification
- Statement of how long the facility has been vacant
- Date of proposed disposal
- Signature of the installation commander
- Approval from installation medical commander

j. IFS-M: All buildings, including medical, are reported in the installation's Integrated Facilities System Mini/Micro (IFS-M) by the Public Work's (DPW) Real Property specialist. Information in the IFS-M database includes size, age, available utilities, building materials, user, original cost, and capitalized improvements. Every quarter, the DPWs real property records are downloaded to the Center for Public Works, at Ft. Belvoir, where all of the Army's real property records are kept on a system called Headquarters Integrated Facilities System (HQIFS). The Pentagon and Department of Army staff has access to the real property records through HQIFS. The HQIFS data is used by numerous decision makers and was extensively used

during BRAC. Decisions regarding mobilization expansion capability, facility investment potential, and infrastructure readiness are based in part on HQIFS data. These decisions may negatively impact on your facility if the HQIFS data is not accurate.

k. Building Ownership: All buildings at your installation are "owned" by the installation Commander. The installation Commander has a Memorandum of understanding (MOU) and an Interservice Support Agreement (ISSA) with the Medical Commander for the use of buildings at the installation. The DPW provides services (fire protection, security, utilities, real property IFS-M reporting, and possibly others, such as maintenance) based on the MOU and ISSA.

l. Approval process: The only person at the installation who can change the use of a building in the IFS-M database is the Real Property specialist. The Real property specialist has to obtain permission from their higher headquarters to change the use of buildings. Changing a building to, or from, a medical use category code needs approval from HQ MEDCOM, ACSIE&FM. ACSIE&FM also coordinates all VETCOM and DENCOM conversion requests for approval.

m. Leases: Leases for additional space off post must be processed through the DPW and the local District Army Corps of Engineers. The lease process requires a minimum of 6 months lead-time. All Army leases are required, by law, to be processed through the Army Corps of Engineers.

n. Relocatable buildings: A Relocatable Building is designed for the specific purpose of being readily moved without structural damage and a minimum of refurbishment. The Army uses the term "Relocatable Building" to describe any of several types of structures including office trailers, modular buildings, prefabricated buildings, pre-engineered buildings, etc. The method of construction is secondary to the fact that the structure can be readily moved. Reference AR 415-15, Army Military Construction Program Development and Execution and AR 420-18, Facilities Engineering Materials, Equipment, and Relocatable Building Management for additional information.

(1) Relocatable Buildings may be obtained to meet both temporary or permanent facility needs. However, the acquisition procedures are distinctly different.

(2) A Relocatable Building acquired to meet a permanent facility requirement is acquired as real property in accordance with AR 415-15. Provided the total cost of the building including site preparation is less than the new construction authority limit delegated to the installation, the building may be acquired using the same approval process as any MEDCOM Operation and Maintenance, Defense (OMD) Minor Construction project. If the total cost of the building or group of buildings is equal to or above the new construction authority limit delegated to the installation, the building is acquired as a MEDICAL MILCON project or an MCA project. Early coordination with the installation Director of Public Works (DPW) is essential to insure site approval. The building will become installation Real Property upon completion as with any construction project.

(3) A building acquired to meet a facility requirement of less than 3 years must be obtained as personal property in accordance with AR 420-18 dated 3 January 1992. This regulation states that installation Commanders may lease

relocatable buildings in association with Real Property Maintenance Activity (RPMA) or DPW funded maintenance, repair, or construction projects, provided the use is solely for furnishing temporary accommodations for personnel or functions during project execution. Specifically excluded from the AR 420-18 approval process are building types and forms provided as an integral part of a mobile equipment item. In these cases where the building is an incidental part of a mobile equipment item such as a communication van or blood mobile, the following approval process does not apply. Other temporary uses require approval at the MACOM level or higher.

(4) Appendix B of AR 420-18 specifies the details of a request for use of relocatable buildings and should be submitted to the Assistant Chief of Staff for Installations, Environment, and Facility Management (ACSIE&FM). Although there is no limit on the size of the project, approval levels are generally based on project size with the top approval level at the Assistant Secretary of the Army for Installations, Logistics and Environment. An economic analysis is required to insure that all alternatives have been considered including lease of off post facilities (if feasible), lease on post, and purchase. Appendix B of the regulation also explains funding options, which include OPD (Medical Care Support Equipment-MEDCASE), and Research Development Test and Evaluation (RDTE) for the purchase option and OMD and RDTE for the lease option. Again, early coordination with the DPW is required to determine if existing facilities are available and to insure site approval.

(5) The activity is not allowed to "keep" the building if purchased as personal property. Disposal and an approved reuse are the only options available at the end of the approved period of use. In extremely rare instances a relocatable building may be converted from personal property to real property with approval through the funding MACOM, the Center for Public Works and the Office of the Assistant Secretary of the Army for Installations, Logistics, and the Environment.

o. Integrated Modular Medical Support System (IMMSS): The intent of IMMSS is to provide a quality interior furnishings system for MEDCOM facilities worldwide. IMMSS is a demountable and relocatable furniture, furnishings and equipment system composed of components, including but not limited to panels, rails and vertical and horizontal wall supports, work surfaces, storage units and electrical and plumbing hardware, that is panel/rail/wall support connected and supported to provide work stations and combined to meet various functional requirements of the facility. These products enable facilities to avoid product obsolescence due to changes of operation, equipment and personnel needs. IMMSS respects this intent and provides maximum product integration and flexibility to accommodate changing medical technology and functional requirements. The products are durable, flexible, safe, have a professional appearance and are functional within the healthcare setting. IMMSS coordinates and complements the building design and other furnishing items within a facility.

(1) Product capability: A wide selection of components is provided to meet clinical, administrative, pharmaceutical and lab system, nurse station and material handling requirements. Products are modular and capable of being relocated anywhere within the facility. Components are designed to accommodate material movement in areas of large material flow. The complete line of products benefits the entire facility from multi-occupancy admin offices to clinical need areas. IMMSS provides the ability to relocate workstation components from one location to another as functions change. There are four advantages of this contract that will complement construction and renovation projects. This contract is especially

beneficial when used in conjunction with a MEDCOM renewal project or a restoration, modernization project. A one time Federal Prison Industries (FPI) waiver/exception is required. (Note: The FPI waiver requirement is frequently reviewed and the process can change. Contact HFPA for current guidance). Various support services include:

- Design Services
- Restorative Services
- Inventory services
- Reconfiguration services
- Panel fabric replacement services
- Clinical and functional analysis services
- Trade-in services
- Transportation Services
- Warehousing Services
- Extended Installation

(2) Equipment provided under IMMSS is considered "personal property" not "real property" in accordance with AR 735-5. This means activities are required to use their core budget capital expense equipment program funds. Some exceptions may apply, (in some cases, IMMSS product may be procured with Initial Outfitting funds or transition funds when purchased under a MILCON or Capital Investment project). Under certain circumstances, extended installation resulting in modifications to the facility (real property) may be funded by alternate sources. However, IMMSS is predominantly personal property and considered equipment and paid for by the activity. Facility Managers will not normally use their "K" dollars provided by MEDCOM to purchase IMMSS. There are some exceptions regarding the extended installation portion of the work if the extended installation repairs or alters real property and existing real property installed building equipment. Please contact HFPA if you have questions.

(3) Details on the contract such as pricing and elevations of the IMMSS components (pictures) can be found on the MILCARE web site at:
http://www.hermanmiller.com/healthcare/government

p. Nurse Call Systems: Many hospitals need to update or replace their antiquated systems. The ACSIE&FM and the Deputy Chief of Staff for Logistics have entered into a joint venture focusing on updating this critical communication system. Facility Managers and Chiefs, Property Management Branches should determine if their system needs updating or replacing. Such factors as reliability, maintainability, and technical obsolescence, should be considered. The nursing staff is a vital source of information on how the system meets their needs. Departments of Nursing may volunteer to assign a nurse project officer to evaluate the existing system and to recommend upgrades or replacements.

(1) Nurse Call system Classification: Nurse call systems are personal property (fixed). See AR 735-5. The nurse call system is not considered as installed building equipment (DA Pam 420-11).

(2) Funding: Nurse call systems must be purchased using Other Procurement Defense (OPD) funding under the Medical Care Support Equipment (MEDCASE) program. Minor construction or repair funding cannot be used to purchase new, replace, or upgrade nurse call systems. The MEDCASE program pays

for all equipment and installation costs. The ACSIE&FM site preparation program pays for site preparation and utility rough-in requirement.

8-27. MASTER PLANNING

a. General: The purpose of the Master Plan is to assess the facility's current health care services, identify current and future facility needs, and recommend strategies for facility development needed to accommodate anticipated growth and/or change in the facility an/or its mission. The Master Plan will provide a guideline to assist the facility in identifying proactive solutions to changing mission requirements. The benefit of the master planning process is that it allows senior leadership an orderly transition plan from current facilities to a future health care delivery environment based on predicted resource needs. This insures that future changes or renovation projects are not only considered individually but for how they affect the facility as a whole. This process also enables the organization to match missions with facility capabilities. In addition, a pro-active department-level facility Master Plan, which is developed in accordance with both the Regional Strategic Health Care Plan and the specific medical activity business plans or strategic planning efforts, is required to guide the Facility Manager and the HFPA so that needed facility repairs, upgrades, modifications, restoration, modernization or replacement projects are planned and executed based upon a comprehensive Master Plan. Projects that are properly planned, phased, funded, and prioritized, in accordance with the supporting business plan, and hence the Master Plan, will provide cost effective and efficient facility solutions to the MEDCOM Facility Life Cycle Management program.

b. Description: The effort contained in the scope of work will provide the subject facility and MEDCOM/HFPA with a Master Plan for department-level (laboratory-level) space planning correlated with health care analysis and planning. The end result will include a list of prioritized project technical solutions to any facility and operational space deficiencies with a phased plan of correction, and other required deliverables. These solutions and corresponding quantifiable support will follow the methodology listed below to ensure compatibility with other MEDCOM/HFPA master planning products. The Master Planning effort will contain both a General Scope which outlines the process and products required for the Master Planning effort and a Project Specific Scope which outlines details, timelines, additions or deletions from the General Scope, delivery schedule, required analysis or services not outlines in the General Scope, and any deliverables associated with those tasks. Each Master Plan will identify specific requirements outlined in the Project Specific Scope. These requirements will be tailored to the specific organization. However, the General Scope provides guidance to ensure that products from all master-planning efforts allow for a corporate comparison. Requirements for the General Scope are detailed below.

c. Process:

(1) Project Initiation: This includes a briefing to the Commander, or his representative, on project goals, assumptions, process and schedule. Coordination prior to the initial briefing may be required with the organization. The Contractor will be required to perform site visits and coordination with regional and corporate management to obtain, evaluate and validate site specific data such as facility assessments, Statements of Condition, business plans, raw data (population

workload, staffing) and other information deemed necessary. At the completion of the site visit, the contractor will be required to submit an in progress review or summary report. Specific site visits will be coordinated directly with the local leadership. HFPA will be informed of all site visits and a mutually agreed upon calendar will be agreed upon in advance. The following will be the typical number of site visits:

- Initial data collection
- Follow-up data collection
- 15% - Engineering/ Infrastructure Assessment
- 25% - Health Planning Review
- 50% - Staffing, PFD, scenarios and concept design options
- 90% - Final Planning review with test & fit options and draft phasing approach
- 100% - Final test & fit options with discrete projects, final phasing approach and cost estimates

The contractor shall be required to complete the number of site visits required to develop the identified site-specific deliverables. An estimate of site visit requirements will be agreed upon.

(2) Health Care/Business Analysis: Contractor will use retrospective and prospective data analysis to generate trends. Different alternatives will be developed based on alternative futures identified by the organization.

(3) Data Collection – Planning: Contractor will collect and analyze any workload, staffing, and customer base information to help validate any previous business planning efforts. This includes, but not limited to, validation of the mission statement, business plans, beneficiary population data (MCFAS, user MCFAS and user CHCS), workload data (MEPRS/CHCS), and staffing (TDA or contracted staff).

(4) Demand Analysis: Contractor will develop a demand analysis based on population served, enrollment (into TRICARE Health, TRICARE Dental Plan, and other enrollment programs). Based on this analysis, contractor will develop utilization trends.

(5) Planning Scenarios: Contractor will develop provider and staffing requirements, volume thresholds/optimization, and functional alignment options. These options will be based on the various futures identified by the organization.

(6) Space Requirements Forecast. Based on the scenarios and requirements listed above, contractor will develop Program for Designs (PFDs). These PFDs will demonstrate the space required to meet the planning scenarios and demand analysis.

d. Site/Facility Analysis:

(1) Data Collection – Facilities: Contractor will collect all existing space utilization plans, architectural CADD or hard copy drawings, site drawings, list of current projects and any facility assessments or deficiency tabulations. This information will be integrated into the assessments conducted as described in the following paragraph [(2), below].

(2) Site/Facility Assessment: A detailed engineering/infrastructure assessment will be conducted incorporating the Facility Condition Index (FCI) concept. This will include a minimum of the following: Site; Exterior Structure; Structure; Interior Structure; Heating, Ventilation and Air Conditioning Systems; Plumbing Systems; Electrical Systems; and Fire Safety. A summary of deficiencies and improvements will be provided and stratified by system, building, category and priority. Each deficiency and improvement will identify a cost estimate (based on RS Means) and outline the useful life remaining for the component (identify year upgrade is required). Priorities will be broken out as follows:

#1 Immediate Concerns;
#2 Short Term Concerns (1-2 years);
#3 Long Term Concerns (3-5 years);
#4 Improvements; and
#5 New Code Requirements.

A minimum of the following categories of deficiencies will be provided:

Code Compliance;
Building Integrity;
Functionality;
Appearance;
Energy;
Air/Water Quality;
Hazardous Materials;
ADA/Accessibility.

A replacement value will be generated for each building and campus/installation based on the sum of replacement costs for each component listed above.

FCI = deficiencies and improvements/replacement value

(3) Analysis Summary and Display: FCI will be calculated for each building and campus/ installation. A minimum of three funding scenarios will be developed to display the impact on FCI over a 20-25 year life cycle. FCI and funding scenarios will be used to assess the relative condition of buildings, campuses and installations to promote valid comparisons throughout the AMEDD.

e. Facility Planning Scenarios. Based on the Health Care/Business Operations Analysis and the Site/Facility Analysis, the contractor will conduct a functional facility analysis resulting in alternative architectural solutions. Facility planning will be summarized in both narrative and graphic representations. All graphics will be submitted in CADD (single-line architectural only) and color coded, based on the following categories: inpatient, outpatient, ancillary, administrative, and support.

f. Existing conditions: The current space utilization and departmental boundaries of the existing structures will be documented in existing condition drawings (CADD).

g. Master plan concept: Departmental function alignment options (big-block design) will be developed in narrative and CADD format and will be based on the projected PFD and future health care scenarios. These drawings will be submitted in

the interim and final deliverables, but will also be used as a tool by the contractor to facilitate alternative development with the MTF leadership.

h. Plans of correction: Final master plan concept and test-fit design will be developed as the culmination of health care analysis, site/facility assessment and facility planning. The plans of correction will be a comprehensive use/reuse plan for the organization's total infrastructure requirement (all buildings identified in the project specific requirements). The plan will account for facility opportunities and constraints and solutions will comply with all applicable standards and health care codes to include the following: life safety; ADA; JCAHO; NFPA; OSHA; AALAC; CAP; and AIA. Test-fit design will be developed for specific projects that are identified as the organization's priority. These projects will be categorized based on the Levels of Facility Alteration outlined in MIL-HDBK-1191, Section 1, General Guidance. The purpose of the test-fit design includes the following: graphic presentation of how specific functions fit into identified space; precursor to full design or work plan development; and to provide detailed information for cost estimate development.

i. Implementation Plan and Cost Estimates: Based on the agreed upon alternatives, the contractor will develop a sequenced phasing of projects based on funding opportunities and constraints. The implementation plan will detail how an organization can execute the moves, upgrade, renovation and/or replacement objectives outlined in the plans of correction. Phasing and order of projects will be aligned in tracks based on their interdependency. Phases are intended to reflect functional, engineering and transitional requirements. Project descriptions will contain general scope and cost estimates will be sensitive to the integrated engineering and architectural findings but will also consider different funding options (i.e. O&M, Host Nation, MILCON) and alternative timelines particular to the military.

j. Final Reports: The contractor shall document the results of all analysis, planning, recommendations, and discussion with regard to the specified deliverables in a final report. A separate executive summary shall also be submitted. The narrative will be directly keyed to supporting graphics and photography. The contractor shall also provide supporting digital photographs and graphics including CD-ROMs with CADD drawings.

(1) In addition to the contracting officer's requirements, there shall be one combined final report and executive summary for each of the following. Copies of the Reports will be called out in the Project Specific Scope and provided to the following:

(a) The Subject Facility/Organization

(b) The Regional Medical Command (RMC), (if subject facility/ organization is a sub-unit of an RMC)

(c) The U.S. Army Health Facility Planning Agency, Falls Church, Virginia

(d) U.S. Army MEDCOM, Assistant Chief of Staff for Installations, Environment and Facility Management (ACSIE&FM), Fort Sam Houston, San Antonio, Texas

k. The final report as well as all other deliverables will be provided in an INTEGRATED electronic format (word processing, spreadsheets, databases and computer-aided design). Electronic format should allow users to manipulate files with existing software (Acrobat, MS Office, AutoCAD). Format should also be easily converted to html for posting to HFPA web site. Besides electronic versions, all deliverables should be printed in 8 1/2" x 11" loose leaf or A-4 notebook. Final report will include as a minimum the following sections:

(1) Executive Summary: The contractor shall prepare an Executive Summary that includes the following sections: Scope and Methodology (summary of deliverables, schedule and team composition); Site/Facility Analysis (infrastructure requirements, FCI for each building and FCI summary); Health Care Planning (summary of population, workload, health care scenarios and recommendations); Health Facility Planning (summary of projects, costs estimates and phasing). The purpose of executive summary is to summarize all major findings and recommendations concisely.

(2) Health Care Planning, Analysis and Recommendations: The methodology, health care/business planning issues, analysis, operational issues, population & enrollment, reorganization plans (product line development) and future staffing approaches will be addressed. The PFD(s) will be included as an Appendix.

(3) Facility Analysis and Problem Definition: The Facility Condition Index methodology, building summary, deficiencies by category, detailed deficiency data by building, and supporting graphic illustrations and/or photographs. Also included is an analysis of costs for building deficiencies corrections and improvements and their impact on future capital investment costs. Architectural analysis to include existing space, existing condition drawings and narrative summaries will be included.

(4) Master Plan Concepts and Alternatives Investigated Site, architectural and engineering alternatives based on the futures of the organization. Various plans will be categorized under each of these alternatives. The following will be included: Existing and programmed square footage matrix; site concept; architectural concept; engineering concept; and the master plan concept (integration/ culmination).

(5) Final Facility Recommendations: The following will be summarized in narrative and graphic formats: Final Master Plan Concept (from among alternatives investigated); Project Recommendations (based on final concept design); Plans of Correction (single line test and fit project recommendations); Cost Estimates (matrix with individual project costs and total costs); Timeliness and Phasing (graphic representation of how the organization can implement the master plan concept and plans of correction).

(6) Appendix: The following will be included as Appendixes: Methodology (detailed narrative summarizing the total endeavor), PFD, Departmental Analysis (includes existing and alternatives investigated, all tools developed to obtain buy-in on the master plan concept will be included), Background (historic information related to the installation, geographic and region will be included).

8-28. EQUIPMENT SITE PREPARATION

Facility managers are often required to coordinate and develop projects for installation of medical care support (MEDCASE) equipment. Prior to delivery and installation of the equipment, certain utility and/or facility modifications are required. To efficiently implement equipment site preparation projects, it is important the facility manager be knowledgeable of equipment purchases well in advance of equipment arrival at sire. It is the facility manager's responsibility to ascertain all equipment purchases, and review, program, and budget for their associated site preparation. Installation normally consists of physically attaching the equipment to the real property facility (building) and providing devices, plumbing, cabling, or wiring necessary to attach the equipment to the existing utility systems or those utility outlets previously made available through site preparation. Costs for the transportation, assembly, installation, calibration, and testing of equipment will not be included in the request for site preparation funding.

a. Work Limitations: Prior to delivery and installation of the equipment, certain utility and/or facility modifications may be required. Only that work which is specifically required to make the piece of equipment operate is eligible to be funded as site preparation. Work generated for aesthetic or functional reasons will not be included in equipment site preparation projects. The preparation of site may include, but is not limited to, items such as:

(1) Secondary utility work necessary to connect the equipment to existing utility services within the building. This work lies between the primary entry or source within the building and the room in which the equipment is to be placed.

(2) Installation of air conditioning for types of equipment where the manufacturer's written specifications states that the equipment must be operated in an air-conditioned space and provides temperature and/or humidity parameters which cannot be sustained by existing air conditioning.

(3) Provision of false floors or platforms required solely for the operation of the equipment.

(4) Installation of required shielding for electromagnetic radiating devices such as X-ray machines and linear accelerators.

b. Funding: Most work eligible for funding as site preparation will be classified as "nonconstruction" (i.e., engineer's RPS account) by the DPW. The DPW is responsible for properly segregating and classifying all work. This guidance is applicable to new equipment ($100,000 and greater in price) purchased through the MEDCASE Program, excess equipment approved for relocation to satisfy MEDCASE requirements, and other equipment on a case-by-case basis. Any site preparation project under $1,000 will be funded from local resources. All projects over $1,000 will be submitted for site preparation funds. Refer to MEDCOM Regulation 700-2, *Operation and Maintenance, Army (OMD) Equipment Site Preparation Program*.

c. Project Execution: Once design and project execution has been funded by ACSIE&FM in accordance with the MEDCOM Form 255-R (DHP-Funded Equipment Site Preparation Project Request) submitted by the medical activity, request for additional funds will be made in writing. Prior to incurring any additional obligations for which ACSIE&FM reimbursement is expected, the ACSIE&FM Program Manager

must be consulted telephonically to ascertain the availability of funds and the appropriateness of the expense. Activities are not authorized to reprogram funds provided for a specific project to any other requirement unless such reprogramming is approved by the ACSIE&FM Program Manager in writing. Activities are required to intensively monitor site preparation projects and report excess funds to the ACSIE&FM Program Manager. Projects including maintenance and repair items (RPMA Account) will contain a statement by the activity (facility manager) that funds will be provided to cover these requirements.

d. Design: Design can be initially funded by the MTF from their regular resource distribution, if available. The cost of design should not exceed six percent of the estimated project cost. Upon approval of final design, the cost for design will be reimbursed along with project funding.

e. Project approval and funding procedures.

(1) MEDCOM FORM 255-R (OMD-Funded Equipment Site Preparation Project Request) will be used to justify all equipment site preparation submitted for MEDCOM funding.

(2) An approved work request form (DA Form 4283) showing evidence of DPW approval and cost summary.

(3) A copy of DPWs detailed cost estimate showing the work items segregated into the various engineer work classifications: Maintenance/Repair, Minor Construction, and Equipment-In-Place.

f. Preplanning and coordination: The actual "installation" of equipment normally begins after receipt, acceptance, and issue of the item to the user: however, proper planning and preparation will be done before receipt so timely installation can occur. In most cases, site preparation should be planned and completed prior to the equipment delivery date. Early planning and coordination with the DPW to determine a realistic date when site preparation will be completed will assist in establishing a delivery date for the equipment.

8-29. REPLACEMENT

AR 415-15, Army Military Construction Program Development and Execution, establishes Army policies, responsibilities, and procedures for the development and execution of Military Construction, Army (MCA) and Unspecified Minor Military Construction, Army (UMMC) programs. Section 1-20 of AR 415-15 specifies responsibilities of The Surgeon General in Medical Military Construction Programs. DA Pam 420-9 shows an MCA program development flow chart, illustrating the process for MCA program design through execution.

a. Projects for construction of new or replacement facilities must be submitted to Congress for funding if their costs exceeds specified limits. The process for preparing the documentation for Congress is known as construction programming. Typically the installation master planner who works within the Directorate of Public Works prepares this documentation.

b. Construction programming is divided into several funding categories. The medical construction program (MED MILCON) is used to fund construction of new clinics, hospitals, medical training facilities, and medical research facilities. Military Construction Army (MCA) is used to fund the construction of barracks, administrative buildings, childcare centers, and many other types of non-medical projects.

8-30. IDENTIFYING REQUIREMENTS

Identifying requirements for the MED MILCON program is the responsibility of the entire Army Medical community. Once identified, MED MILCON projects are included in the Future Years Defense Plan (FYDP). The objective of a 50-year life cycle for the medical infrastructure can only be achieved if requirements for construction projects are identified early in the planning process and supporting documentation is carefully completed.

8-31. MED MILCON DEVELOPMENT

To develop the MED MILCON Program, each year the Office of the Secretary of Defense (Health Affairs) (OSDHA) requests a prioritized listing of all requirements for MED MILCON projects for a six year period. The Army's listing of projects is developed by the Major Subordinate Commands and submitted through the U.S. Army Health Facility Planning Agency (USAHFPA) and the Army Staff (ARSTAF) to OSD(HA). Typical projects include:

a. Complete replacement of a facility. Criteria for a justification for a replacement facility include:

(1) There is an additional mission.

(2) The current facility is substandard and cannot pass accreditation (even if the LSU or ADAL is performed.

(3) An economic analysis identifies a new facility as more cost effective than the LSU or ADAL.

b. Consolidation of two or more freestanding facilities. Consolidations generally occur when two or more facilities are required for one mission. Justification for consolidation depends on the condition of the facilities and the impact numerous facilities have on the mission.

c. Addition and/or alteration (ADAL) to an existing facility. An ADAL is required when space, services, or systems are required in addition to the existing facility. This assumes that the existing facility is in adequate or repairable condition.

d. Life safety Upgrades (LSU): LSUs are required when National Fire protection Association (NFPA) standards are not met, or when the facility cannot obtain JCAHO accreditation. Generally, JCAHO accreditation is not obtained due to facility deficiencies, which cannot be remediated with simple repairs or corrections.

8-32. DOCUMENTATION

Documentation required for MED MILCON projects is:

a. Project Planning Package:

(1) DD Form 1391: DD Form 1391 is the form that officially requests project authorization and appropriation by Congress. As soon as a MED MILCON requirement is identified, a DD Form 1391 should be initiated. The MED MILCON program is a six-year program. The fiscal year of execution of a MED MILCON project can be estimated to be six years from the time of project identification. The fiscal year of execution will be adjusted annually, as the MED MILCON project develops. With few exceptions, such as a Congressional insert, DoD requires that project identification be at the 35 percent design (concept) stage before the DD Form 1391 is submitted to Congress.

(2) Project Narrative summarizing the sizing decision process, siting, significant planning information and results.

(3) Program for Design, (PFD, space program), including the required number of parking spaces.

(4) Equipment Planning: DMFO is responsible for planning for installed (built-in) medical and dental equipment and the associated budgeting to support this requirement (MILCON). DMFO shall provide the using Military Department with an initial equipment listing based on the Program For Design for their review and input prior to furnishing the document to the Design Agent. Each equipment list may be tailored or modified by the using Military Department as appropriate. Equipment in Logistical category Codes E and F may be altered by the using Military Department if funding source requirements are not exceeded.

b. The Project Book (PB) summarizing existing site conditions and utilities. The following information, at minimum, is required:

(1) Area maps, location maps, site location, site description (to include grades, gates, etc), style of architecture, construction season limitations, seismic, wind and snow considerations, SOFA, host country agreements, soil and foundation conditions, utility conditions (water, sewer, power, steam, electrical capacities and location), site restrictions (airfield, AICUZ potential helipad approach/departure zone obstructions, flood land, rights-of-way, etc.), and National Capitol Planning Region (NCR) considerations, etc.

(2) Utility availability, existing fuel sources, central heat or chilled water systems and capacities, power service characteristics and locations, electrical distribution, water and wastewater considerations.

(3) Environmental impact requirements, archaeological and historical considerations, explosive ordinance locations, contaminated soil (fuel, asbestos, etc.), coastal zone considerations, wetlands and watershed considerations, threatened and endangered species considerations, water quality, air quality, asbestos contamination, protection of natural resources information, and any other

Environmental Protection Agency (EPA) or Occupational Safety and Health Administration (OSHA) considerations necessary which might impact the MILCON project.

(4) Security requirements, contingency or BLAST considerations. AT/FP requirements.

(5) Fire protection considerations, such as accessibility and water supply.

(6) Communications, information or data systems, telephone and signal interface requirements for fire, police, etc., telephone switch capacities and line availability for MILCON project, Energy and Utility Monitoring and Control System (EMCS, UMCS) interface, master antenna, cable TV and closed circuit availability, computer interface, and all other similar or useful information.

(7) Preliminary analysis of replacement versus addition/alteration where requested by DMFO.

(8) Completed site survey.

8-33. MEASURING PERFORMANCE

Facility management performance is based on both internal program review and external benchmarks. Internal program review is accomplished through the Command Logistics Review Team (CLRT). External benchmarks, such as maintenance and minor repair funding, and level of maintenance staffing, are compared against private sector figures.

8-34. FACILITY MANAGEMENT COMMAND LOGISTICS REVIEW TEAM (CLRT)

A facility management survey questionnaire for the CLRT has been developed to measure the success of MEDCOM facility management programs, and to provide guidance in the implementation of comprehensive facility management programs at the activity level. The questionnaire is meant to be a working document, which will be periodically reviewed and modified, when required. Results of the survey will be used to grade the overall effectiveness and to rank the success of facility management programs in facility.

a. The questionnaire is divided into eight categories. They are:

- Facility Management Organization and Staffing
- Operations and Maintenance
- Project Management
- Resource/Financial Management
- Regulatory/Accreditation Compliance
- DMLSS
- Administration and Training
- Physical Plant and Site Survey

b. Survey documentation: The facility manager should review the checklist and have the required information available as supporting documentation during the CLRT survey.

8-35. TRAINING AND CAREER DEVELOPMENT

The transition of facility operation and maintenance responsibilities to a reimbursable basis creates a need for a career development program that will prepare health facilities personnel for new and expanded facility management roles in the future. In addition, the requirements of accreditation agencies, such as the Joint Commission of Healthcare Organizations (JCAHO), places significant emphasis on physical plant management and reinforce the need for a comprehensive facilities career enhancement and educational program.

a. The facility management career enhancement program goals are to determine functional skills required for facility managers, identify primary training, educational, and developmental requirements, and develop staffing methodology to maintain a high level of expertise in all MEDCOM facilities. Many functional skills have been identified, and are being addressed in basic and advanced facility management courses.

b. Madigan Army Medical Center (MAMC) has been designated as the MEDCOM Center of Technical Expertise (CTX) for Facility Management. All facility management training and career enhancement guidance and policy determination is established through the CTX. The CTX will also offer technical guidance to MEDCOM on O&M issues.

c. Training and Educational Programs:

(1) A DOD Tri-Service Medical Logistics Facilities Management training program has been established to cover the basis areas necessary to manage health care facilities. The purpose of the course is to provide a broad overview of DOD Medical facility management, and to insure that facilities are operated and maintained in accordance with applicable standards, such as JCAHO, NFPA, OSHA, and EPA.

(2) The Facility Management Applied and Continuing Education Course, FM-ACE is offered through MEDCOM with the assistance of the CTX. The course is an applied continuing education course. An advanced facility management course is offered by the CTX. The purpose of the advanced course is to provide facility managers with state-of-art information on a wide range of facility issues, such as computerized maintenance management systems (CMMS), reliability based maintenance, and enhancement of customer service.

(3) The U.S. Army Corp of Engineers, Huntsville Division, offers many training courses related to facility management through the Proponent Sponsored Engineer Corps Training (PROSPECT) course. Facility managers can contact COE directly for application to courses.

(4) The USAF Material Command, School of Aerospace Medicine, Brooks AFB, TX., offers environmental courses in hazardous waste and emergency response,

as well as other environmental courses. Also, Fort Sill, OK, Directorate of Environmental Quality, offers a comprehensive program for environmental training.

(5) Some universities offer degree programs and short courses in facility management related subjects. At the time of this publication, a listing of these programs and courses is not available.

d. Facility Certification Courses:

(1) The American Hospital Association offers a Certified Health Care Facility Manager certification exam for qualified facility managers.

(2) Certification as a Facility Management Administrator (FMA) is offered through BOMI Institute, Arnold, MD.

(3) Other facility management certification programs include the Certified Plant Maintenance Manager course through the Association for Facilities Engineers and the Certification in Health Facility Management (CHFM), offered through the American Society of Healthcare Engineers (ASHE).

e. Funding: Funding for training, education, and certification is the responsibility of the activity. In some cases, sustainment funds can be used for this purpose (refer to the latest MEDCOM Facility Information Bulletin for limitations).

f. Career Development:

(1) Facility Management Training:

(a) Facility Management Basic Course:

Held at Sheppard Air Force Base Wichita Falls, Texas
Frequency: Five times per year.
Duration: Three-week course
Intent: To introduce Facility Managers to the basic overview of the Medical Facilities Management Program. Intent is to teach the Integrated Facility Life Cycle Management philosophy.

(b) Facility Management Applied and Continuing Education Course:

Held at various locations
Frequency: Annually
Duration: One week
Intent: To provide information for facility managers and facility directors. The course is sponsored by the Center for Facility Management Technical Expertise, Madigan Army Medical Center, Fort Lewis, WA.

(c) Health Facility Planning Agency Post Graduate Short Course:

Held at different sites every other year.
Frequency: Annually
Duration: One week

Intent: To enhance tri-service and interagency collaboration and synergy on execution processes and lessons learned to realize improved efficiencies and quality in all phases of health facility planning, design, and construction.

(d) Joint Services Facility Management Symposium:

Held with the American Society of Health Care Engineers. Held at different sites each year.
Frequency: Annually
Duration: Five Days
Intent: Professional development for all Facility Managers and Facility Directors. Includes the benefit for all attendees to obtain up-to-the-minute information on healthcare engineering by attending the ASHE conference held the same week at the same location.
Briefings: Exportable Training

(e) Corps of Engineers, Huntsville, AL; Corps of Engineers DFW:

On-site training.
Duration: Four hours
Intent: To familiarize COE engineers and architects with the Facility Manager's duties and responsibilities in a healthcare facility.

(f) Health Services Medical Materiel Management Course:

AMEDDC&S
Duration: Two hours
Intent: To familiarize Logisticians with the organization and responsibilities of the Facility Management Branch in a Medical Treatment Facility.

g. At the time of this publication, CPR 950-18, Army Civilian Career Program for Engineers and Scientists, is the only program for facility management and engineering career advancement. This program is being reviewed for inclusion of career elements that are hospital and research facility specific.

h. Intern program: This program is operated through Madigan Army Medical Center Engineering Department. Applications are accepted on a bi-annual basis. Contact MEDCOM for detailed information.

CHAPTER 9. MEDICAL MATERIEL READINESS

9-1. MEDICAL MATERIEL READINESS BACKROUND

a. Class VIII materiel support for Army Units is divided into several categories:

(1) Non-Unit Assemblage (UA) materiel (clinician or mission specific, non-standardized)

(2) Non-Centrally managed UA materiel (Unit funded, centrally standardized)

(3) Centrally Managed (the USAMMA and DSCP-managed, standardized)

(4) Medical, Nuclear, Biological, Chemical Defense Materiel (MNBCDM - MEDCOM/USAMMA-managed, standardized, controlled distribution to all types of Units)

(5) Army Pre-positioned Stocks (APS – geographically distributed, DA owned, USAMMA managed)

b. The USAMMA is responsible for the initial fielding of the Medical Materiel Sets (MMS) and MES that comprise a Unit Basic Load (UBL). These SKOs are currently fielded with a 90 percent fill as outlined in AR 40-61. The IMSA is the source of supply to fill Unit-generated shortages (consumed items, Unit assemblage updates, expired items, and field losses) for all Units. In order to maintain readiness, all supplies must be on-hand, on order, or part of a pre-arranged agreement where previously identified items may be obtained through Prime Vendors or other contract sources. It is the Unit's responsibility to maintain their basic load, unless centrally managed. Units must submit funded requisitions to procure these items. The IMSA will map requirements to ensure that there is a viable acquisition tool in place to procure these items. The Unit is required to make an annual coordination with the IMSA to identify shortages and coordinate sources of supply.

c. All medical Units must coordinate their requirements for medical materiel to their supporting IMSAs annually. Reserve Units will maintain only the non-expendable and durable components of their UBL. The IMSA will be the source of supply to acquire the Class VIII expendable UBL items to support Reserve Component (RC) Units upon mobilization. The IMSA will match these requirements to a source of supply to ensure rapid acquisition. All Units will validate that the acquisition timeline supports their wartime mobilization mission.

d. Division And Below (DAB) Units must maintain their basic loads and fill Unit generated shortages, UA updates and mission specific items. The AMEDD does not centrally manage materiel for divisional Units. DAB medical Units are expected to deploy with their entire Class VIII Unit Basic Load. For rapid deployment/ contingencies; however, DA Deputy Chief of Staff Operations (DCSOPS) may identify and direct that a DAB Unit will be supported by centrally managed Brigade set from APS (SB 8-75-S7). These directions will be published in the applicable Operations Order (OPORD).

e. The USAMMA centrally manages Class VIII materiel for early deploying Active and Reserve Medical Units at the echelon above Division (EAD) level. This materiel serves as initial deployment medical Unit basic load (UBL) for deploying Units. The materiel contained in this program is identified in the SB 8-75-S7. The USAMMA, MEDCOM, and the deploying Unit will coordinate for acquisition and hand off of class VIII materiel in a contingency. The Medical Logistics Support Team (MLST) is the medical materiel hand-off team that is an integral part of the Army Materiel Command (AMC) Logistics Support Element (LSE). The MLST will hand off Class VIII Unit Deployment Packages (UDP) and APS as directed by the USAMMA in coordinated effort with the deploying Unit.

9-2. MEDICAL MATERIEL READINESS LEVELS OF SUPPORT

a. Division Units: For Units in Divisions, Regiments, and Separate Brigades, medical materiel support is provided by the Division/Brigade/Regiment Surgeon's Office via either the Division Medical Operations Center/Division Medical Supply Office (DMOC/DMSO) (legacy system) or the Division Materiel Management Center (DMMC) Medical Supply section (interim system). Medical Materiel in Combat Units is highly standardized, decentralized (controlled and managed by operational funds at the lowest level), and sustained by the owning Unit.

(1) Fielding of UBL: Units are fielded their MESs and other authorized medical items by the USAMMA. The USAMMA Fielding Team conducts scheduled fieldings of Unit MES and other centrally managed SKOs within the Division. The USAMMA provides a one-time fill for the SKO and upon completion of fielding, transfers accountability to the Unit to maintain and provide status on the SKO through command channels.

(2) Unit shortages/ Sustainment of UBL: Units are funded and expected to maintain their sets to the highest level of fill to ensure readiness of the sets. Initial fill shortages are filled by ship shorts from the USAMMA or direct funding to the Unit to order locally to fill any SKO shortages. Sustainment of the sets is the responsibility of the Unit commander and Division Surgeon (DS). Units will have materiel available within 72 hours. This means that materiel will either be accounted for as on-hand, on-order with a valid status, or directly available from the source of supply (for unfunded requirements). Units will validate annually through their source of supply (DMSO, DMMC, IMSA) the availability of all materiel requirements that are currently not on hand. Sets with specialty items (Chemical Patient Decontamination) or short shelf-life items (Field Laboratory) will be closely managed to avoid expiration of vital components.

(3) Medical, Nuclear, Biological, and Chemical Defense Materiel (MNBCDM): Deployable Force Package (DFP) assets of MNBCDM are centrally managed to support initial issue, Individual Service Member (ISM) requirements for Army personnel deploying to high threat areas. This materiel is identified as project code DH1 assets. Assets can only be released after obtaining the approval of the Office of the Surgeon General (OTSG) Ops XXI Center at DSN: 761-2128, COMM: 866 677-2128, email at: **opns@otsg.amedd.army.mil**. OTSG Operations will authorize the release of the DFP MNBCDM. The receiving Unit will sign and maintain an audit trail of all MNBCDM received from the IMSA. Individual issue of the CANA and antibiotics (CIPRO or Doxy) are not authorized until directed by the theater CINC. The CANA and antibiotics must be bulk shipped with the senior individual.

CANA is Schedule IV, CIIC Code Q, controlled substance and requires secure storage. Typically, the CANA is controlled per AR 190-51, in a Unit cage or safe. Turn-in of MNBCDM is performed upon redeployment. Units must account for all MNBCDM issued and not consumed. If assets were issued to individuals, then this materiel will be so annotated and reported to the USAMMA for destruction. Assets maintained in bulk storage will be reported to the USAMMA for disposition instructions. A storage history is required. MNBCDM components of MESs will be reported to the USAMMA for disposition instructions six months before assets reach their expirations date. Replacements will be funded by the Units (except MES, Chem Agent Patient Trmt which will be centrally managed for Force Package 1 & 2 plus forward deployed) when assets reach their expiration date.

(4) Mobilization/deployment instructions: Upon deployment or mobilization notification, Units will validate their deployment CL VIII DODAAC and order all shortages from the supporting IMSA/SSA for receipt and packaging. Unit UBL is typically considered To Accompany Troops (TAT) and loaded with other Unit equipment. It is essential that these Units deploy with 100 percent of the required capability as sustainment is based upon that planning assumption.

b. Echelons Above Division: For Corps and higher echelon Units, the typical structure of a Medical Group, Brigade, or Command will have medical logistics elements specifically designated to support the medical materiel and equipment requirements for those Units. Unit medical supply personnel will integrate via automated systems into the MEDLOG Company Combat Automated Support Server - Medical (CASS-M) system to order shortages and validate status. Units will order and maintain their basic load except where covered by a Centrally Managed program as discussed below. Where Units are not supported in garrison by their MEDLOG Company, they will maintain active accounts with their IMSA for all deployment and training CL VIII requirements.

(1) Fielding of UBL: the process for these Units is essentially the same as Divisional Units; the key difference for selected EAD Units is the coverage by UDP for various Unit types (see SB 8-75-S7). For Units covered by UDP, only select materiel is fielded to accompany the nonexpendable and durable (Accounting Requirements Code (ARC) N and D) components of Medical SKOs. Potency and Dated (P&D) items between 12 and 60 months of shelf life are centrally managed in the UDPs associated with those Units, and the Units are not required to maintain or sustain those lines. For Units not covered by a UDP, the requirement for those Units is no different from Divisional Units – maintain sets to 100 percent on-hand, on-order, or validated as available from the local source of supply.

(2) Unit shortages/Sustainment of UBL: Units covered by UDP will maintain only designated "non UDP" covered lines at 100 percent fill. Units not covered by UDP will maintain highest level of fill funded and validate all unfunded requirements through source of supply to ensure acquisition capability subsequent to deployment funding supplements or project codes.

(3) (MCDM): Units will draw/issue/turn-in their MNBCDM in the same manner as Divisional Units.

(4) Mobilization/deployment instructions: Per SB 8-75-S7, Units supported by UDP will maintain current contact information with the USAMMA and support fielding and issue plans for that materiel. Except for early deploying Units

falling in on APS (UDP and other items), Units will plan and transport CL VIII TAT. EAD medical Units are typically more diverse than Divisional Units, and acquisition strategies to cover the greater range of requirements must occur annually between the IMSA and the Unit.

(5) Redeployment: Units redeploying will either conduct a transfer of centrally-managed assets to the relieving Unit (in place) or turn in the centrally-managed assets to the supporting Medical Logistics Unit for return to Centrally managed programs. Retention of those centrally managed assets requires further accountability by those Units until they turn-in those items.

c. MTOE Hospitals (Active Component): Medical Force 2000 (MF2K) and Medical Reengineering Initiative (MRI) hospitals represent the Echelon 3 and 4 (North Atlantic Treaty Organization (NATO) Role 3) requirements for surgical stabilization and intensive care management of casualties. They also provide Direct Support for subordinate assigned and attached Units, and Area Support for medical logistics when not co-located with MEDLOG Detachments or Companies.

(1) Fielding of UBL: The USAMMA provides centralized fielding and modernization of MTOE hospitals. Units are fielded to the current POM budget for that year, typically resulting in a 90 percent fill of non-UDP covered Medical Materiel and Medical Equipment Sets. Additionally, APS cover early strategic hospitalization requirements due to the large transportation requirement required to move Hospitals.

(2) Unit shortages/Sustainment of UBL: Units are expected to maintain the fielded level of fill for their sets regardless of their designation as an early deployer (required to fall in on APS). Those Units designated to utilize APS hand their sets off to the Reserve Installation Commander, who assists the USAMMA MLST in preparing those items for concurrent shipment to a late deploying hospital or augment Reserve Component Hospital Decrement (RCHD) if necessary.

(3) MCDM: Units will draw/issue/turn-in their MNBCDM in the same manner as Divisional Units. Hospitals with a DS support requirement will also order and distribute MNBCDM in accordance with their DS support instructions. (For example, a CSH that supports 3 FSTs will provide MNBCDM and other supply support for those FSTs).

(4) Mobilization/ deployment instructions: Upon confirmation of deployment orders, the designated Unit will either receive augmentation in the form of UDP at mobilization station (assisted by the USAMMA MLST) or (for early deploying Units) move via airlift (TAT only) and fall in on APS (also assisted by the USAMMA MLST).

d. MTOE Hospitals (Reserve Component)

(1) Fielding of Mission Essential Equipment Training (MEET) sets: MEET sets are the nonexpendable and durable components of selected MMS modules that make up a reserve hospital. MEET sets allow reserve hospital commanders the opportunity to perform the major tasks of setting up (complexing) hospitals and establishing the physical layout without buying and maintaining a vast amount of expirable or maintainable items. MEET sets are fielded by the USAMMA to reserve component medical hospitals. Units conducting normal Reserve training (drill/annual

Training (AT)) are expected to purchase expendable components with training funds to make the MEET sets capable of supporting training objectives.

(2) RCHD Program: RCHD augments the MEET sets to fill out the remaining requirements to make the hospital fully operational for mobilization and deployment. RCHD assets are stored at Sierra Army Depot (SIAD) and fielded to the Unit at the mobilization station. The Unit and the USAMMA MLST field RCHD.

(3) MNBCDM: Units will draw/issue/turn-in their MNBCDM in the same manner as Divisional Units. Hospitals with DS requirements will support in the same manner as Active MTOE hospitals.

(4) Mobilization/deployment instructions: Upon receipt of an alert order, Unit Reserve Support Center liaisons should initiate contact with the USAMMA to begin the process of identifying the Unit RCHD requirements to augment MEET sets. Reserve Units, as late deployers, are expected to bring their full equipment load to the mobilization station, to further augment with RCHD to the full capacity of their respective MTOE strength. Units will also receive any supporting UDPs at this time and flow with full equipment. Selected Reserve Units may fall in on active component sets that were released by Active APS supported hospitals.

(5) Re-deployment: Reserve Component (RC) Units will redeploy with their equipment. Federal Law requires that RC Units maintain accountability within their component – meaning that Active Component (AC) Units cannot fall in on RC equipment unless they exchange equipment or receive exception consideration from DA G-3/G-4 via sourcing MACOM (FORSCOM, USARPAC/EUSA, USAREUR). Upon redeployment, Units will return RCHD elements to the RCHD program with assistance from the USAMMA MLST and Materiel Fielding Team.

e. All Units

(1) All Units will conduct annual coordination (establish an account with a supporting medical supply activity) and validate all requirements (on hand, on order, and materiel required that may be unfunded or currently unavailable).

(2) Units are expected to maintain the highest level of readiness for which they are funded. Units are expected to deploy at greater than 90 percent of MTOE required strength for equipment in order to be certified by an installation commander.

(3) Units will receive applicable centrally managed materiel (typically MNBCDM) upon receipt of valid deployment orders or by Surgeon General directed and approved release (contingency support requirements).

9-3. MEDICAL MATERIEL READINESS SUPPORTING AGENCIES

a. MACOM (FORSCOM/USARPAC-EUSA/USAREUR): Sourcing Unit MACOMs will provide Unit funding and identify requirements for all medical (SRC 08) Units under their commands. MACOMs are responsible for supporting the required CONPLAN and OPLANs with Units that are adequately resourced to meet the warfighting CINC's requirements.

b. USAMEDCOM/OTSG: Programs, budgets, and executes central management of the CL VIII commodity, to include DA-funded, centrally-managed programs (APS, MNBCDM, UDP, ISP) and commercial business interaction. Provides doctrine, regulation, and policy for the medical force.

c. MRMC: Serves to integrate the testing, research, and materiel developer to identify the future medical threat, treatment requirements and provide the standardized support for MTOE organizations. Commands the USAMMA and USAMMCE, the two MEDCOM/OTSG materiel agencies that provide assembly management and other centrally managed support to CONUS and OCONUS theaters.

d. The USAMMA: Serves as the designated central medical materiel manager for MEDCOM/OTSG. Manages strategic and operational medical materiel programs that support MTOE Units in all components. Serve as the materiel developer for Army standardized sets.

e. RMC: RMCs shift assets to support major mobilization requirements and provide resource management and contracting support to adequately support installation and deploying Unit requirements at the direction of MEDCOM/OTSG. Direct IMSA actions to support mobilization, deployment, and redeployment activities.

f. IMSA (PPP/PSP): Provide direct support for all standard and non-standard requests for medical materiel and equipment maintenance. Conduct coordination and validation of CL VIII requirements with all supported Units on an annual basis. Assist with storage and distribution of MEDCOM/OTSG centrally managed programs. Mobilization stations provide the support to deploy TOE forces, fill deploying Units to meet CINC force requirements, expansion of medical facilities and transition support to reserve elements to sustain the Mobilization station missions for continuing support through all phases of Army operations.

g. DSCP: Provide DLA/DoD interface for the CL VIII commodity. Provide commercial contracting and medical materiel support capability through DWWCF/Defense Capital Operating Fund.

h. MLMC: Provides an automated Single Integrated Medical Logistics Manager (SIMLM) support function for the warfighting CINC, collecting and providing detailed medical materiel management functions allowing real-time commodity management and feedback to the force provider to ensure complete logistics coverage for a theater of operations.

i. AMEDDC&S: Develops the doctrine, validates the current standards of care, and trains the medical logistician. Coordinates the training and modernization of the medical force with other Services and within the DA.

j. DCDD: Serves as the combat developer, integrating doctrine and standardizing requirements in conjunction with the expressed capability requirements of the combat force.

9-4. OCONUS MEDICAL LOGISTICS SUPPORT

a. USAMMCE: This TDA organization serves as the SIMLM for EUCOM, Africa, and SWA. Provides medical materiel management, depot level medical maintenance, and multivision optical fabrication for all services.

b. 16th MEDLOG BN: This TDA-augmented MTOE organization serves as the SIMLM for Korea. Provides medical materiel management, GS medical maintenance, and multivision optical fabrication for all services on the Korean peninsula.

9-5. MEDICAL, NUCLEAR, BIOLOGICAL, AND CHEMICAL DEFENSE MATERIEL (MNBCDM)

a. MNBCDM is centrally managed by the DA, OTSG and executed by the USAMMA. The DFP was developed to provide initial issue of MNBCDM to individual service members deploying to high threat areas. Project code DH1 applies to the DFP assets. The DA has included Installation Support Packages (ISP) as part of the centrally managed program. Installation Commander can authorize the release of the ISP assets to respond to an event of a major disaster involving Chemical, Biological, Radiological, Nuclear or High Explosive (CBRNE). Project code DH3 applies to ISP assets. Both the DFP and ISP MNBCDM items are issued on a non-reimbursable basis.

b. Policy for the MNBCDM program is disseminated by the OTSG via MMI messages. Specific guidance on storage, accounting, and project codes is available in OTSG Operations Management Bulletin (OMB) No. 12-02, dated 17 June 2002. Additional information is published in the SB 8-75 series publications. The MMI messages and the SB8-75 publications can be accessed on the USAMMA web page.

c. DFP sets are stored in strategic locations throughout the world with the USAMMA maintaining visibility and performing COSIS on each package. Units should not have these items on hand unless mission or threat requires issue. These sets will support the initial stages of a contingency while allowing the industrial base adequate time to move into full production. DFP may contain all or a portion of the following items:

NSN	ITEM	QUANTITY
6505-01-174-9919	Antidote Treatment Kit Nerve Agent (Mark I Kits or Nerve Agent Antidote Kit – Projected replacement: 6505-01-362-7427, Nerve Agent Antidote Delivery System (NAADS). Basis of issue is 3 per soldier.	15,000
6505-01-274-0951	Diazepam Injection 5 mg/ml Syringe Needle Unit (Convulsant Antidote Nerve Agent-CANA). Basis of issue is 1 per soldier	5,000
6505-01-178-7903	Pyridostigmine Bromide Tablets 30 mg, 210 tablets/package (PB Tabs or Nerve Agent Pre-treatment Pill – NAPP). Each package contains 10 strips of 21 tablets. Basis of issue is 2 strips per soldier	1,000
6505-01-491-2834	Ciprofloxicin 500 mg. 30 tablets	
6505-01-491-5506	Doxycycline Hyclate Capsules USP 100MG I.S., 30's	
6505-01-496-4916	Potassium Iodide 130 mg Tablet. 1 pkg of 14 tabs/individual	
7610-01-492-7703	Soldier's Guide to MBCDM	5,000

d. Each item of the DFP is tracked by lot number and expiration date. The USAMMA uses this information to budget for and requisition replacement material.

e. DFP release procedures:

(1) All releases of the centrally funded MNBCDM will be approved by Headquarters, Department of the Army (HQDA) and coordinated with the USAMMA.

(2) Deploying Units will pass requests for initial issue MNBCDM to their Class VIII Supply Support Activity (SSA). Units must provide their IMSA: Unit Identification Code (UIC), Unit Line Number (ULN), Operation Plan Number or Deployment Order Number (from deployment order), and the quantity of material required.

(3) The SSA will provide the UIC, ULN, and quantity required to the USAMMA, Emergency Operations Center (EOC), DSN 343-4408/4347/4461 or 301 619-4408/4347/4461. If the request is valid, the appropriate type and quantities will be approved for release. Release instructions will be communicated from MEDCOM to the RMC. If the IMSA is not a DFP storage site, material will be sent from the nearest DFP facility/depot.

(4) Upon return from a deployment, Units will turn-in the MNBCDM to the IMSA. Documentation for shortages must be provided.

(5) Units will deploy with MNBCDM TAT unless directed to do otherwise per 0PORD or other Directive.

f. Pyridostigmine Bromide Tablets (PBT)

(1) PBT is still considered an Investigational New Drug (IND). FDA approval is required before the material can be released to individual soldiers for use.

(2) Requests for FDA approval must be submitted. The Theater CINC states the threat and the need to use PBT to the Joint Chiefs of Staff. The Assistant Secretary of Defense (Health Affairs) requests that the FDA allow DoD to use PBT under the IND protocol.

(3) The IND protocol requires an audit trail to be maintained for the issue and use of PBT.

g. MNBCDM required as components of MES, SKOs, Explosive Ordnance Teams, Chemical Accident/Incidence Response Assistance (CAIRA).

(1) This material is excluded from centrally-managed program and is Unit funded.

(2) Units must submit funded requisitions to their supporting IMSA with the following information:

(a) UIC
(b) Justification for requested requirement
(c) LIN or NSN of the SKO/MES
(d) Number of sets authorized and on hand

(3) The IMSA will forward the requisitions to the USAMMA via fax, DSN 343-4404/COMM 301 619-4404. Approved requisitions will be forwarded to Defense Support Center Philadelphia (DSCP) for processing.

9-6. COMMON READINESS MATERIEL ITEMS

CTA 8-100 is the source for all deployable Unit common medical items (chap stick, foot powder, first-aid kits, etc.). These items are requested through the supporting IMSA. CTA 8-100 provides a basic guideline for the quantity of items to order for a given Unit. Unit supply personnel order these items using OMA funds.

a. Combat Lifesaver (CLS) Bags/Training: These are service-regulated items. They are ordered through the supporting IMSA with a justification memorandum attached detailing the personnel who will receive the MES, and their current training qualification. Only currently certified CLS personnel will receive the MES. Units will store the controlled components of CLS bags to prevent misuse IAW AR 190-51 (Unit safe, with designated/controlled access; inventoried quarterly). MES CLS is accounted for as a durable item and hand receipted to the user level.

b. Patient Movement Items (PMI): PMIs are initially issued with SKOs to using Units. Replenishments are done by line-item requisition or direct exchange on a one-for-one basis with other Units during patient transfer. PMIs are service-certified for Air-Worthiness Standards based on Service specific airframes and are intended to be used on the service associated evacuation platforms. Hand receipted durable items are accounted for by item, not serial number or other marking

method. Nonexpendables are controlled by serial number except where transferred for patient evacuation (ambulance exchange).

c. Moulage: Casualty Simulation sets, or moulage sets, are CTA authorized items. Typically, the supporting installation Training Aid Support Center (TASC) will maintain sets for use. Otherwise, Units will order the sets according to CTA 8-100 through their servicing IMSA. The sets are durable items and replenished by line item requisition.

9-7. SOLDIER READINESS PROCESSING (SRP)

a. MEDCOM Responsibility for SRP/PDP is to provide screening checks for medical, dental, and visual readiness. Personnel are given updated medical examinations, dental examinations, vaccinations, eye examinations and medical appointments to ensure that all necessary standards of fitness are achieved prior to deployment. IMSAs are funded to provide those basic services and are coordinated by the hosting installation for Unit SRP functions.

b. Supplies are ordered from the supporting IMSA and paid for by that activity for all SRP requirements.

(1) Theater prophylactic requirements are defined by the sourcing and requiring commands. Vaccinations and other forms of prophylaxis are distributed prior to deployment and managed by the Unit surgeon for continued treatment upon deployment. Personnel medical records are updated during SRP to show initial vaccination and issue of prophylactic medicines.

(2) Optical devices will be prescribed and issued prior to deployment of personnel from the Mobilization station. The basic requirement will be two pair of standard eyewear and one protective mask insert for those personnel who meet the vision readiness requirement for corrective eyewear as determined by competent medical authority.

9-8. MEDICAL MATERIEL READINESS SPECIAL CONSIDERATIONS

These categories of items require special attention and management beyond what has been addressed previously. Additionally, these are specific readiness items that affect Unit deployments and sustainment due to acquisition restrictions and distribution controls that aren't regulated by USAMEDCOM/OTSG policies. (Controlled substances are discussed in other chapters of AR 40-61 and AR 190-51).

a. Lab Reagents: Lab reagents are characterized by three important factors:

Limited Shelf Life,
Temperature Regulation, and
Limited Commercial Production.

As such, laboratory reagents are typically acquired by either local purchase or utilizing DSCP E-CAT web ordering tool from a vendor. Lab reagents may have long lead times for acquisition utilizing standard ordering procedures. The expected

means of acquiring these items is through utilization of the DSCP ESOC for deploying and deployed medical Units requiring lab reagent support.

b. Cold Chain management: Temperature controlled (cold storage and frozen items) requires specific transportation controls to ensure that they maintain their viability between source and patient delivery. For items requiring cold chain management functions, the supporting SIMLM or the USAMMA Pharmacy division will support all packing and transportation instructions to ensure that adequate cold chain management measures are performed. Suspect medical materiel will be segregated and reported using SF 380 (Materiel Complaint) procedures to prevent patient injury or death.

c. Hazardous Materiel (HAZMAT): HAZMAT will be transported according to DOT and DoD requirements for safe movement. HAZMAT will be stored according to specific storage instructions for each item and category of HAZMAT. Additionally, applicable MSDS and other OSHA requirements will accompany all HAZMAT items for storage, shipment, and usage. HAZMAT is packed and shipped separate from other supplies and equipment and specific instructions on handling will be clearly marked on each package or container. Personnel who handle HAZMAT will be certified according to MACOM and OSHA requirements before transporting, packing, or handling HAZMAT items.

CHAPTER 10. PROCEDURES FOR MANAGEMENT OF MEDICAL ASSEMBLAGES

10-1. ACCOUNTING, MANAGEMENT, AND UPDATE OF MEDICAL ASSEMBLAGES

a. Accounting and managing for components of Medical Assemblages

(1) Commanders, MTOE units will:

(a) Establish and maintain:

(1) Property accounting records on each authorized nonexpendable item using the manual property accounting procedures, or (see DA PAM 710-2-1).

(2) An approved DA automated property accounting system.

(b) Establish a viable QC program for all dated items.

(c) Not manage under the inventory provisions of AR 710-2 and DA PAM 710-2-1, expendable or durable [accounting requirements code (ARC) "X" or "D"] components of MES on hand receipts (SC 6545-8 series) or as part of the Unit Assembly Listings (UAL). These items are listed in the SC or UA listings to identify authorized component quantities. Medical items are classified as durable because they are not expended in the first use. Unless there is evidence of pilferage, the loss of these items should be treated as if they were expendable items. Commanders are not required to account for durable losses from MES/MMS under the provisions of AR 735-5, paragraph 14-25, where negligence, theft, or willful misconduct is not suspected.

(d) Inventory MES components against the authorized UAL at least every 6 months (12 months in RC) to assure readiness. This inventory may be performed in conjunction with other required inventories as long as the inventory meets the requirements stated above.

(1) Commanders of Caretaker Hospitals whose equipment is placed in long-term storage will follow procedures outlined by their MACOM.

(2) The items listed in the section 2 of the fielded unit assembly listing and SC 6545-8 series are ASIOE end items dedicated to the operation and/or maintenance of the medical assemblage. They are listed for information purposes only and do not constitute an additional authorization. Total authorization is reflected on the unit's MTOE/TDA.

(e) Record and account for the inventory as follows:

(1) For assemblages with published hand receipts, use the preprinted hand-receipt lists provided to record the results of inventories and maintain accountability.

(2) For assemblages without published hand receipts, prepare a DA Form 4998-R (Quality Control and Surveillance Record for TOE Medical Assemblage) for each expendable and durable item in the medical assemblage.

(3) Use DA Form 4998-R to record and manage QC information. Reproduce DA Form 4998-R locally on 8X5-inch card stock. See Table 10-1 for instructions on how to complete DA Form 4998-R.

(4) Automated procedures. The DA approved automated medical materiel management systems that provide assemblage management and QC capabilities must be used in lieu of DA Form 1296 and 4998-R, if available.

(2) The MTOE hospitals and division MSOs will accomplish the following for ASL items in anticipation of their resupply mission.

(a) Establish a DA Form 1296 for each item, for which demands are expected. Use the component listing of authorized MES and CTA 8-100 as a guide. Detailed instructions for using stock accounting records are in DA PAM 710-2-2. These forms, with support records, will be used to informally manage supply activities upon mobilization. Advance preparation will enhance operational readiness upon mobilization or deployment.

(b) Establish a DA Form 4998-R for each medical item that has a shelf life and for which demands are expected. This form will help in managing QC actions required.

(c) Automated procedures. The DA approved automated medical materiel management systems that provide assemblage management and QC capabilities must be used in lieu of DA Form 1296 and 4998-R, if available.

TABLE 10-1. STEPS TO PREPARING DA FORM 4998-R

STEP	DESCRIPTION
1	NO: Number sequential, for example 1, 2, 3 (Pen)
2	LOCATION: Where is the item stored for example, box, ISO, cabinet, or drawer. (Pencil)
3	MANUFACTURER: Name of manufacturer (Pen)
4	CONTRACT NO: Contract number/purchase order/document number, if available (Pen)
5	LOT/BATCH NUMBER: Lot number/batch number from item (Pen)
6	EXP/MFR DATE: Manufacturer date and/or expiration date (month-year)(Pen)
7	QTY ON HAND: Amount you have on hand as of the most recent inventory for that manufacturer, lot number and expiration date (Pencil)
8	DATE LAST INSPECTION: Date of last inventory (Pencil)
9	DATE OF NEXT INSPECTION: A minimum of 6 months (12 months RC) from the date of last inspection (Pencil)

	(continued) TABLE 10-1. STEPS TO PREPARING DA FORM 4998-R
STEP	DESCRIPTION
10	NSN: National Stock Number, Universal Product Code, or Management Control Number of the item (Pen)
11	DESCRIPTION: Name of the item plus characteristics, for example 2 ml, sharp point, tapered, and 6/pg (Pen)
12	UNIT OF ISSUE: Unit the item is ordered in, for example EA, PG, or BX (Pen)
13	NOTES: Special shelf life notes, for example Note Q – control substance and Note P – needs refrigeration. See UDR/FEDLOG. (Pen)
14	INSPECTION FREQUENCY: How often does the item need to be looked at? Based on AR 702-18, UDR, or DOD Medical Category, Volumes I & II (Pencil)
15	SHELF LIFE/ESTIMATED SHELF LIFE: Based on expiration date. AR 702-18 (Pencil)

b. Update of Medical Assemblages

(1) Commanders of Non-Hospital Units will:

(a) Maintain their UA to the (UAL) configuration under which they were fielded.

(b) No longer be required to purchase the OMA-funded component to cyclic MES changes. Units will move forward to the new UAL configuration, and corresponding NSN, when fielded by USAMMA.

(c) Not be precluded from selectively upgrading OMA-funded set components to the most current configuration if unit funding is available. If commanders choose to selectively upgrade set components, they will do the following:

(1) Inform any changes to the

USAMMA
ATTN: MCMR-MMR-A
1423 Sultan Dr., Suite 100
Fort Detrick MD 21702-5001
DSN 343-7161 or COMM 301-619-7161

(2) Execute an NSN change IAW DA PAM 710-2-1 to property accountable records for sets that have been upgraded.

(3) Not be fielded OPA-funded support items out of the sustainment cycle to coincide with a unit-funded upgrade.

(2) Commanders of DEPMEDS equipped units will inventory medical assemblage against the UAL fielded with the unit until authorized by USAMMA.

10-2. PROCEDURES FOR LOAN OF MTOE MATERIEL (EQUIPMENT) IN SUPPORT OF PROJECTS AT HEALTHCARE ACTIVITIES (HCAS)

a. Procedures for submitting a request for loan of MTOE materiel:

(1) The requesting HCA will prepare an MOA/MOU that will include the following enclosures:

(a) Enclosure 1 – General information. Include the:

(1) Quantity and type of equipment needed.
(2) How long the equipment will be needed (not to exceed 10 months).
(3) Any support requirements.

(b) Enclosure 2 - Coordination with the HCA's quality improvement coordinator/risk management committee.

(c) Enclosure 3 - Coordination with the HCA's PM office where the following have been assessed:

(1) Water
(2) Solid, liquid, and hazardous waste management
(3) Sanitation
(4) Radiation protection issues

(d) Enclosure 4 - Economic analysis: The economic analysis must consider several alternatives that might resolve the impacts of construction. The alternatives might be the:

(1) Relocation of services to existing buildings
(2) Lease of space or mobile buildings
(3) Curtailment of services
(4) Use of other Federal facilities (other service or Department of Veterans Administration (DVA)

(e) Enclosure 5 - Return of equipment plan: The return of equipment plan should address:

(1) Maintenance issues
(2) Methods of recovery
(3) The DEPMEDS unit's provisions for potential contingencies

(f) Enclosure 6 - Site layout: The layout should:

(1) Be coordinated with the installation's Director of Public Works to determine the location and availability of utilities.
(2) Consider JCAHO's fire, safety, and operation standards.

(g) Enclosure 7 - Cost estimate and availability of funds.

b. Procedures for Loan of medical equipment to units from USAMMA:

(1) Army medical equipment that belongs to the wholesale logistics system (USAMMA) may be loaned for one or 2 years through the Army Authorization Documents System (TAADS) "MOC" windows of change.

(2) The loan must be requested by the PBO on DA Form 4881-6-R (Request & Approval for Loan or Lease of Equipment & Loan or Lease Agreement). See AR 71-32 and AR 700-131, chapter 2 for completion of this form.

(3) Loan requests for more than one year must be accompanied by DA Form 4610-R (Equipment Changes in MTOE/TDA).

(4) Requests will be sent to USAMMA for availability and issue if approved.

(5) The Commander, USAMMA can approve all loans that do not exceed 180 days or affect the Department of the Army Master Priority List (DAMPL). Loans that affect DAMPL must be approved by the

Commander, USAMEDCOM
ATTN: MCLO-P
2050 Worth Rd, Suite 8
Fort Sam Houston TX 78234-6008

CHAPTER 11. OPTICAL FABRICATION

11-1. OPTICAL FABRICATION AUTHORITY AND OVERVIEW

a. Optical fabrication has become a consolidated effort within DOD. In response to this consolidation, the Optical Fabrication Enterprise (OFE) was formed, with the Navy Surgeon General designated as the Executive Agent (EA). The OFE was created to manage the DOD's optical fabrication assets, and meet optical fabrication requirements of all services. The OFE charter includes all Defense Health Program (DHP) supported laboratories.

The EA in turn designated the Commander of Naval Ophthalmic Support and Training Activity (NOSTRA) to provide day-to-day oversight of the enterprise. To manage and maintain DOD optical fabrication, an Optical Fabrication Advisory Board (OFAB) was established.

The OFAB acts as the primary advisor to the EA. The OFAB operates with a combined staff consisting of members from the Army, Air Force, Navy and one representative from DOD's Secretariat. The chairman of the OFAB is the U.S. Army Medical Command's Assistant Chief of Staff for Logistics.

b. The Army optical fabrication laboratories (OFL) and Units fabricate prescription eyewear that includes spectacles, protective mask inserts, and similar ocular devices for eligible personnel under AR 40-63/NAVMEDCOMINST 6810.1/ AFR 167-3.

c. This chapter identifies requirements used for the management of Army optical fabrication laboratories located at both MTDA and MTOE activities/Units.

11-2. OPTICAL FABRICATION ENTERPRISE REPORT

a. The Consolidated Optical Fabrication Enterprise Report provides data on optical devices fabricated by optical laboratories and Units. It is used in

(1) Planning mobilizations
(2) Preparing budgets
(3) Assigning opticians (42Es)
(4) Analyzing inter-service support
(5) Utilization of manpower
(6) Analyzing cost/production efficiency

11-3. COMPLETING OPTICAL FABRICATION ENTERPRISE REPORT WORKSHEETS

a. General information and instructions for completing and submitting the OFE Report worksheets are available from the USAMEDCOM, ACSLOG, Logistics Plans and Readiness Division, or the Naval Ophthalmic Support and Training Activity (NOSTRA).

b. The report is located on **http://www.medlogspt.army.mil** and is a fully integrated, online, data-reporting tool. The OFE Optical Fabrication Web-tool consists of four reports with content-sensitive instructions integrated within each metric. The OFE reports consist of four different metrics titled: Production, Financial, Staff, and Performance. These on-line reports have been developed to capture data and additional information required by OFE and USAMEDCOM.

c. To access from the web, use **http://www.medlogspt.army.mil** and personnel must register on the site then contact USAMEDCOM ACSLOG, Logistics Plans and Readiness Division for access to the OFE optical Fabrication web-tool. Once verification and user-level is determined, access will be granted to the OFE Web-tool. Clicking on the OFE button (top menu) will bring you to the OFE page. Afterwards, click on the left display menu bar click on Programs. Thereafter, click on the top display areas for the various reports metrics titled, Production, Financial, Staff, and Performance. Once input is made click submit. The information will be stored on an archived retrievable database.

d. Army optical laboratories and Units, including those organized as an element of MTDA and MTOE Units, will:

(1) Submit the consolidated optical fabrication enterprise report monthly located on **http://www.medlogspt.army.mil**.

(2) The submitted report will be staffed/reviewed through command channels to the appropriate RMC or Command Surgeons. The report will then be reviewed by USAMEDCOM by the tenth of each month.

(3) If additional information or guidance is required on this report or optical issues contact:

USAMEDCOM
ATTN: MCLO-P
2050 Worth Road, Suite 8
Fort Sam Houston TX 78234-6008

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GLOSSARY

> Acronyms are listed on pages 1-9
> Terms/Definitions are listed on pages 11-16

Acronyms:

Abbreviation	Definition
AAC	Acquisition Advice Code
AC	Active Component
ACSLOG	Assistant Chief of Staff for Logistics
ACTEDS	Army Civilian Training, Education and Development System
ADAL	Addition or Alteration
ADL	Area Dental Laboratory
ADP	Automatic Data Processing
ADPE	Automatic Data Processing Equipment
A-E	Architect-Engineer
AE	Aeromedical Evacuation
AFM	Air Force Manual
AFR	Air Force Regulation
AIG	Address Indicator Group
AIT	Automatic Identification Technology
AMDF	Army Master Data File
AMEDD	Army Medical Department
AMEDDC&S	Army Medical Department Center and School
AMEDDPAS	Army Medical Department Property Accounting System
APS	Army Pre-Position Stocks
AR	Army Regulation
ARC	Accounting Requirements Code
ARNG	Army National Guard
ASARDA	Assistant Secretary of the Army for Research, Development and Acquisition
ASIOE	Associated Support Items of Equipment
ASL	Authorized Stockage List
AT	Annual Training
AWR	Army War Reserve
BAS	Battalion Aid Station
BASOPS	Base Operations
BES	Budget Estimate Submission
BLAST	Blocked Asynchronous Transmission Protocol
BLIC	Budget Line Item Code
BMAR	Backlog of Maintenance and Repairs
BPA	Blanket Purchase Agreement
BRAC	Base Realignment and Closure
BUMEDINST	Bureau of Medical and Surgery Instruction
CAGE	Commercial and Government Entity
CAIRA	Chemical Accident/Incidence Response Assistance
CANA	Convulsive Antidote Nerve Agent
CAP	Council of American Pathologists
CASS-M	Combat Automatic Support Server - Medical

Abbreviation	Definition
Acronyms:	
CBRNE	Chemical, Biological, Radiological, Nuclear, or High Explosive
CDM	Chemical Defense Materiel
CEEP	Capital Expense Equipment Program
CEMEP	Capital Expense Medical Equipment
CERCLA	Comprehensive Environmental Response Compensation and Liability Act
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHPPM	Center for Health Promotion and Preventive Medicine
CIF	Central Issue Facility
CIIC	Controlled Inventory Item Code
CINC	Commander in Chief
CLRP	Command Logistics Review Program
CLRT	Command Logistics Review Team
CLS	Combat Lifesaver
CMMS	Computerized Maintenance Management System
COE	United States Army Corp of Engineers
CONPLAN	Contingency Plan
CONUS	Continental United States
COR	Contracting Officer's Representative
COSIS	Care of Supplies in Storage
COTS	Commercial Off the Shelf
CPT	Clinical Product Team
CPW	Center for Public Works
CSH	Combat Support Hospital
CTA	Common Table of Allowances
CVC	Calibration, Verification, and Certification
DA	Department of the Army
DA PAM	Department of the Army Pamphlet
DAAS	Defense Automatic Addressing System
DAB	Division and Below
DAMPL	Department of the Army Master Priority List
DAPA	Distribution and Pricing Agreement
DARA	Department of the Army Radiation Authorization
DBBS	Defense Blood Bank System
DBPA	Decentralized Blanket Purchase Agreements
DCDD	Directorate of Combat and Doctrine Development
DCSLOG	Deputy Chief of Staff for Logistics
DCSOPS	Deputy Chief of Staff Operations
D-Day	Deployment-Day (attack-day)
DDN	Defense Data Network
DEA	Drug Enforcement Administration
DEH	Directorate of Engineering and Housing
DENCOM	Dental Command
DENTAC	Dental Activity
DEPMEDS	Deployable Medical Systems
DFARS	DOD Federal Acquisition Regulation Supplement
DFAS	Defense Finance and Accounting Service

(continued) GLOSSARY FOR SB 8-75-11

Abbreviation	Definition
Acronyms:	
DFAS-IN	Defense Finance and Accounting Service - Indianapolis Center
DFP	Defense Force Packages
DHP	Defense Health Program
DIC	Document Identifier Code
DISC	Defense Industrial Supply Center
DLA	Defense Logistics Agency
DLAM	Defense Logistics Agency Manual
DLAR	Defense Logistics Agency Regulation
DLIS	Defense Logistics Information System
DMLSS	Defense Medical Logistics Standard Support
DMMC	Division Materiel Management Center
DMOC	Division Medical Operations Center
DMS	Dental Materiel Set(s) or Defense Messaging System
DMSO	Division Medical Supply Office
DMSO	Division Medical Supply Office
DoD	Department of Defense
DoD MMQC	Department of Defense Medical Materiel Quality Control
DODAAC	Department of Defense Activity Address Code
DODD	Department of Defense Directive
DOIM	Director of Information Management
DOL	Directorate of Logistics
DOS	Days of Supply
DPW	Directorate of Public Works
DRB	Division Ready Brigade
DRMO	Defense Reutilization and Marketing Office
DS	Division Surgeon
DSCP	Defense Supply Center Philadelphia
DSN	Defense Switching Network
DTF	Dental Treatment Facility
DVA	Department of Veterans Affairs
DWWCF	Defense Wide Working Capital Fund
EA	Executive Agent
EA/EIS	Environmental Impact Assessment/Environmental Impact Statement
EAC	Echelons Above Corps
EAD	Echelons Above Division
ECAT	Electronic Catalog
ECIP	Energy Conservation Investment Program
ECP	Exposure Control Plan
EEMP	Excess Equipment Management Program
EO	Executive Order
EOC	Emergency Operations Center
EOH	Equipment On Hand
EOQ	Economic Order Quantity
EPA	Environmental Protection Agency
EP&SD	Engineering, Plans, and Services Division
ESL	Estimated Storage Life
ESO	Environmental Science Officer

Abbreviation	Definition
Acronyms:	
ESOC	Emergency Supply Operations Center
EVS	Environmental Services
EVSO	Environmental Services Officer
EUCOM	European Command
EUSA	Eighth United States Army
FAR	Federal Acquisition Regulation
FD	Facility Director
FDA	Food and Drug Administration
FEDLOG	Federal Logistics Data on Compact Disc
FIA	Financial Inventory Accounting
FLCM	Facility Life Cycle Management
FLIS	Federal Logistics Information System
FM	Field Manual
FMA	Facility Management Administrator
FMLCMG	Facility Managers Life Cycle Management Guide
FORSCOM	United States Army Forces Command
FSC	Federal Supply Catalog
FSM	Facility Sustainment Model
FSMC	Forward Support Medical Company
FSS	Federal Supply Schedules
FST	Forward Surgical Team
FTP	File Transfer Protocol
FY	Fiscal Year
FYDP	Future Years Defense Plan
GCSS-A	Global Combat Support System-Army
GCSS-A-MNT	Global Combat Support System-Army-Maintenance
GCSS-A-SPR	Global Combat Support System-Army-Supply and Property
GFM	Government Furnished Materiel
GFP	Government Furnished Property
GSA	General Services Administration
HAZMAT	Hazardous Materiel
HCA	Health Care Activity
HDV	High Dollar Value
HF	High Frequency
HP	Hewlett Packard
HQDA	Headquarters, Department of the Army
HSAM	Health Systems Analysis and Measurement
IAW	In Accordance With
ICC	Infection Control Committee
ICO	Infection Control Officer
IFS	Integrated Facilities System
IJO	Individual Job Order
IMPAC	International Merchant Purchase Authorization Card
IMSA	Installation Medical Supply Activity
IND	Investigational New Drug
IPD	Issue Priority Designator

(continued) GLOSSARY FOR SB 8-75-11

Abbreviation	Definition
Acronyms:	
IS	Information System
ISP	Installation Support Package
ISSA	Inter-Service Support Agreements
ITO	Installation Transportation Office
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JMMC	Joint Military Medical Command
JRCAB	Joint Readiness Clinical Advisory Board
LAN	Local Area Network
LAP	Logistics Assistance Program
LAV	Logistics Assistance Visits
LIN	Line Item Number
LMC	Linen Management Committee
LMO	Linen Management Officer
LOGCAP	Logistics Civilian Augmentation Program
LPC	Local Procurement Contract
LSU	Life Safety Upgrade
LTS	Long Term Storage
MACOM	Major Command (United States Army)
MAMC CTX	Madigan Army Medical Center of Expertise
MASH	Mobile Army Surgical Hospital
MATDACS	Materiel Distribution and Collection Systems
MCA	Military Construction, Army
MCDM	Medical Chemical Defense Materiel
MCN	Management Control Number
MCO	Marine Corps Order
MCSC	Materiel Category Structure Code
MED	Medical
MEDASM	Medical Assembly Management
MEDCASE	Medical Care Support Equipment
MEDCEN	Medical Center
MEDCOM	Medical Command
MEDDAC	Medical Dental Activity
MEDLOG	Medical Logistics
MEDLOG Bn	Medical Logistics Battalions
MEDMAINT	Medical Maintenance
MEDSTEP	Medical Standby Equipment Program
MEDSUP	Medical Supply
MEET	Mission Essential Equipment Training
MES	Medical Equipment Sets
MF2K	Medical Force 2000
MFP	Materiel Fielding Plan
MHS	Military Heath System
MIDI/MEIS	Military Item Disposal Instructions/Military Environmental Information Source
MIIN	Medical Item Identification Number
MILCON	Military Construction
MIL-STD	Military Standard

Abbreviation	Definition
Acronyms:	
MILSBILLS	Military Standard Billing System
MILSTRIP	Military Standard Requisitioning and Issue Procedures
MIREP	Medical Instrument Recycling Program
MLMC	Medical Logistics Management Center
MLST	Medical Logistics Support Team
MMBP	Military Medical Benefits Property
MMI	Medical Materiel Information
MMPDANBC	Medical Materiel Program for Defense Against Nuclear, Biological, and Chemical Agents
MMQC	Medical Materiel Quality Control
MMS	Medical Materiel Sets
MNBCDM	Medical Nuclear, Biological, Chemical Defense Materiel
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MOV	Materiel Obligation Validation
MPL	Mandatory Parts Lists
M&R	Maintenance and Repair
MRI	Medical Reengineering Initiative
MRMC	Medical Research and Materiel Command
MRO	Materiel Release Order
MSC	Major Subordinate Commands
MSDS	Materiel Safety Data Sheets
MSE	Mobile Subscriber Equipment
MSMC	Main Support Medical Company
MSO	Medical Supply Officer
MSP	Materiel Standardization Program
MTF	Medical Treatment Facility
MTOE	Modified Table of Organization and Equipment
NAADS	Nerve Agent Antidote Delivery System
NAAK	Nerve Agent Antidote Kit
NAAP	Nerve Agent Pre-treatment Pill
NATO	North Atlantic Treaty Organization
NAVMEDCOMINST	Naval Medical Command Instruction
NAVSUPINST	Navy Supply Instruction
NAVSUPPUB	Navy Supply Publication
NDC	National Drug Codes
NEPA	National Environmental Policy Act
NFPA	National Fire Protection Association
NGB	National Guard Bureau
NICP	National Inventory Control Point
NMP	National Maintenance Point
NOSTRA	Naval Ophthalmic Support and Training Activity
NSN	National Stock Number
OCE	Office of Chief of Engineers
OCIE	Organizational Clothing and Individual Equipment
OCONUS	Outside Continental United States
OFAB	Optical Fabrication Advisory Board
OFE	Optical Fabrication Enterprise

(continued) GLOSSARY FOR SB 8-75-11

Abbreviation	Definition
Acronyms:	
OFL	Optical Fabrication Laboratories
O&M	Operations and Maintenance
OMA	Operations and Maintenance, Army
OMB	Operations Management Bulletin
OMD	Operations and Maintenance, Defense
OPA	Other Procurement, Army
OPD	Other Procurement, Defense
OPOD	Operations Order
OSD(HA)	Office of the Secretary of Defense (Health Affairs)
OSHA	Occupational Safety and Health Administration
OST	Order and Shipping Time
OTSG	Office of the Surgeon General
P&D	Potency and Dated
PA	Procurement Appropriation
PAM	Pamphlet
PARC	Principle Assistant Responsible for Contracting
PBO	Property Book Officer
PBT	Pyridostigmine Bromide Tablets
PC	Personal Computer
PD2	Procurement Desktop-Defense
PDP	Predeployment Processing
PM	Preventive Medicine
PMBS	Precious Metals Bearing Scrap
PMC	Precious Metals Coordinator
PMI	Patient Movement Items
PMM	Precious Metals Monitor
PMRP	Precious Metals Recovery Program
POM	Program Objective Memorandum
POU	Point of Use
PPP	Power Projection Platform
PR	Purchase Request
PROSPECT	Proponent Sponsored Engineer Corps Training
PRWeb	Purchase Request Web
PSP	Power Support Platform
PV	Prime Vendor
PWS	Performance Work Statement
QA	Quality Assurance
QASP	Quality Assurance Surveillance Plan
QC	Quality Control
QSTAG	Quadripartite Standardization Agreement
RAMOP	Repair Maintenance Operations Program
RC	Reserve Component
RCHD	Reserve Component Hospital Decrement
RCRA	Resource Conversation and Recovery Act
RF	Radio Frequency
RIA	Regional Incentive Agreements

Abbreviation	Definition
Acronyms:	
RIC	Routing Identifier Code
RMC	Regional Medical Command
RMW	Regulated Medical Waste
RO	Requisition Objective
ROD	Report of Discrepancy
RTS-MED	Regional Training Sites-Medical
SB	Supply Bulletin
SC	Supply Catalog
SCR	System Change Request
SECNAVINST	Secretary of the Navy Instruction
SF	Standard Form or Square Feet
SIAD	Sierra Army Depot
SICC	Service Item Control Center
SIMLM	Single Integrated Medical Logistics Manager
SKO	Sets, Kits, and Outfits
SLC	Shelf Life Code
SLEP-MMQC	Shelf Life Extension Program - Medical Materiel Quality Control
SMDA	Safe Medical Devices Act
SO	Service Order
SOO	Standing Operation Order
SPBS-R	Standard Property Book System - Redesigned
SRC	Standard Requirement Code
SRM	Sustainment, Restoration, and Modernization
SRP	Soldier Readiness Processing
SRTS	Spectacle Request Transmission System
SSA	Supply Support Activity
SSN	Social Security Number
STAMIS	Standard Army Management Information System
SWA	South West Asia
TAADS	The Army Authorization Documents System
TAMMIS	Theater Army Medical Management Information System
TAMMIS-MEDSUP	Theater Army Medical Management Information System-Medical Supply
TASC	Training Aid Support Center
TAT	To Accompany Troops
TAV	Total Asset Visibility
TB	Technical Bulletin
TB MED	Technical Bulletin, Medical
TCAM	TAMMIS Customer Assistance Module
TCSO	Textile Care Services Officer
TDA	Table of Distribution and Allowances
TED	Troop Equivalent Dose
TI	Technical Inspection
TM	Technical Manual
TMC	Troop Medical Clinic
TMDE	Test, Measurement, and Diagnostic Equipment
TMIP	Theater Medical Information Program
TMMMC	Theater Medical Materiel Management Center

(continued) GLOSSARY FOR SB 8-75-11

Abbreviation	Definition
Acronyms:	
TOE	Table of Organization and Equipment
TPF	Total Package Fielding
TRBO	Tri-Service Regional Business Office
TSG	The Surgeon General
TTA	Tactical Terminal Adapter
UA	Unit Assemblage
UAL	Unit Assembly Listing
UBL	Unit Basic Load
UDP	Unit Deployment Packages
UDR	Universal Data Repository
UIC	Unit Identification Code
ULLS-G	Unit Level Logistics System - Ground
ULLS-S4	Unit Level Logistics System – S4 Module
ULN	Unit Line Number
USAF	United States Air Force
USAHFPA	United States Army Health Facility Planning Agency
USAMEDCOM	United States Army Medical Command
USAMEDDBD	United States Army Medical Department Board
USAMISSA	United States Army Medical Information Systems and Services Agency
USAMMA	United States Army Medical Materiel Agency
USAMMCE	United States Army Medical Materiel Center Europe
USAMRMC	United States Army Medical Research and Materiel Command
USAR	United States Army Reserve
USARC	United States Army Reserve Command
USAREUR	United States Army Europe
USARPAC	United States Army Pacific
USPFO	United States Property and Fiscal Officer
USR	Unit Status Report
USSACHPPM	United States Army Center for Health Promotion and Preventive Medicine
UUCP	Unix-to-Unix Copy Protocol
VA	Veterans Affair
VETCOM	Veterinary Command
VMI	Vendor Managed Inventory
WRAMC	Walter Reed Army Medical Center

Terms:

Term	Definition
Accountability	Obligation to keep records of property, documents, or funds, such as item identification data, gains, losses, dues-in, dues-out, and balances on hand or in use. (AR 40-61, AR 710-2, AR 735-5, DA PAM 710-2-1, DA PAM 710-2-2)
Accountable officer	Person officially appointed in writing to maintain a formal set of accounting records of property or funds. This person may or may not have physical possession of the property or funds. Two types of accountability most common to medical facilities or organizations are: a. Formal – Stock record accounting for supplies being held for issue from time of receipt until, issued, shipped or dropped from accountability. (AR 40-61, AR 710-2, AR 735-5, DA PAM 710-2-1, DA PAM 710-2-2) b. Property Book – Accounting for nonexpendable organization property upon receipt and until subsequently turned-in, used (consumed) for authorized purposes, or dropped from accountability. (AR 40-61, AR 710-2, AR 735-5, DA PAM 710-2-1, DA PAM 710-2-2)
Appointing Authority	An appointing authority is an officer or civilian designated by the approving authority with responsibility for appointing report of survey investigating officers. (AR 735-5)
Army Master Data File (AMDF)	An official source of supply management data used in medical logistics. The U.S. Army Materiel Command publishes it monthly.
Army Medical command	An organization that has command over one or more MEDCENs, MEDDACs, or medical research activities. Includes U.S. Army Medical Command, U.S. Army Medical Research and Materiel Command, and 18th Medical Command.
Army War Reserve Sustainment (AWRS)	AWRS is materiel intended to provide essential consumable materiel to sustain combat operations by bridging the gap between initial deployment/initial operations and follow on support from the strategic base once the theater has matured.
Bulk (liquid) gases	A fixed, central system consisting of a main storage tank that pipes oxygen, ethylene oxide, or other types to patient care areas.

Term	Definition
Calibration, verification, and Certification (CVC) services	To determine compliance of medical equipment with applicable specifications or standards and to make the necessary corrections or to compare the item with a certified device, tool, or test equipment standard.
Capital expense equipment program	Equipment having a unit price less than current OPD threshold.
Capital investment equipment	Equipment with a unit price equal to or greater than the current OPD threshold.
Catalog Master Data File (CMDF)	An official source of supply management data used in medical logistics by activities operating under TAMMIS. It is published monthly.
Command Surgeons	Senior Medical Corps officer who is part of the Division/Corps/Theater/MACOM special staff. Keeps the commander informed regarding medical aspects of operations.
Deployable Medical Systems (DEPMEDS)	Standard DOD modular medical and dental materiel sets that are configured into hospitals for use in a wartime theater of operations or as fixed contingency hospitals in peacetime.
Durable item	An item of Army property coded with an ARC of "D" in the AMDF or DOD Medical Catalog. Durable items do not require property book accountability. Durable items are identified with an ARC "D" in the AMDF or UDR. Commercial and fabricated items similar to items coded "D" in the AMDF or UDR are considered durable items.
Exchange of Equipment	Equipment furnished and upgraded by a vendor while under contract for their reagents or software applications. Exchange requires legal confirmation by the Contracting Officer and accountability by the PBO before exchange. There is no exception.
Expendable	An item that is consumed or loses its identity in use. Expendable items are identified with an ARC of X in the AMDF or UDR.
Gas analysis	A measurement of the percentage of the gas in a sample by volume using a battery-operated, portable, hand-held instrument.
Health Care Activity (HCA)	All TOE and TDA facilities that provide medical care and support. Includes hospitals, clinics, dental activities, veterinary activities, combat stress, preventive medicine, logistics, and evacuation.

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Term	Definition
Hospital linen management	A unique system for managing linen in HCA. It is based on the need for responsive, sanitary, and economic linen operations. It consists of all actions involved in the requisitioning, storage, accounting, distribution, repair, cleaning, and safeguarding of hospital linen.
Hospital linen	Linen used in direct patient care or in support of direct patient care. It normally includes selected hospital and surgical clothing and hospital bedding and linen items in the Federal Supply Catalog (DOD Section, Medical Materiel (FSC 6530, 6532, and 7210)) and similar nonstandard items.
Installation medical supply activity (IMSA)	In CONUS, the SSA for medical materiel for an installation or geographic area. OCONUS, it is normally the primary SSA for medical materiel for a designated geographic area.
Leased Equipment	Leased equipment requires legal agreement and accountability. Files should contain authorization, lease agreement with applicable amendments, and receipt of turn-in/return documentation.
Liquid oxygen storage and distribution system	Generation and distribution of liquid oxygen via cylinders in a field environment.
Loaned Equipment	Equipment provided "free of charge" while using vendors' software applications and reagents in the medical arena. This includes vendor equipment furnished with established Blanket Purchase Agreements.
Major Subordinate Commands (MSC)	MSCs under USAMEDCOM; includes RMCs, CHPPM, VETCOM, DENCOM, AMEDDC&S, and USAMRMC.
Management level	An acceptable range of performance expressed with upper and lower control limits. Performance that is not within the acceptable range warrants management review.
Management objective	The point of measured performance that is generally attainable under normal operating conditions.
Materiel demonstration	Showing, use, or application of an item by the vendor. It does not involve any action by Army personnel beyond observing the operation of the product by the vendor.
Materiel Distribution and Collection System (MATDACS)	Internal hospital system designed to increase efficiency and cost effectiveness in the provision of medical logistics support.

Term	Definition
Materiel evaluation	Formal investigation by an activity of materiel that may have AMEDD-wide potential to improve health care or efficiency.
Materiel examination	Use of an item by an activity to determine whether the item or similar item should be purchased. The materiel examination does not generally exceed 30 days.
Medical Care Support Equipment (MEDCASE)	That equipment required in AMEDD TDA fixed health care activities that is authorized for acquisition through OPD and medical MILCON funding programs.
Medical equipment (including dental and veterinary items)	Consists of those devices used in the medical diagnosis, therapy, and treatment of injury or disease. This equipment consists primarily of FSC 6500 items that are standardized by the JRCAB and are procured by the DSCP for TSG to implement health service support for the Army. It also consists of similar commercial, nonstandard items, approved by the Food and Drug Administration (FDA) and marketed as medical devices, used primarily in fixed treatment facilities to provide state-of-the-art patient care. The equipment is maintained and repaired by medical equipment repairers organic to the medical unit or treatment facility.
Medical materiel	Medical materiel includes nonexpendable, durable, and expendable supplies used in HCAs, medical research and laboratory facilities and other medical related institutions and units in the AMEDD.
Medical Standby Equipment Program (MEDSTEP)	Includes end items, components, or assemblies used to support activities with serviceable items when the primary item is unserviceable and is economically repairable (formerly called operational readiness float).
Military Medical Benefits Property (MMBP)	Consists of equipment loaned from a treatment facility to authorized personnel when needed for the treatment of injury or disease.
Medical Equipment Sets (MES)	Grouping of medical and other items under a single NSN, with the components, DLA- or DSCP-managed (may be Service regulated).
Nonexpendable item	An item of Army property that retains its original identity, is not consumed in use and is coded with an ARC "N" in the AMDF or the UDR. Nonexpendable items require property book accountability.

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Term	Definition
Performance measures	A selected indicator that is used as a barometer or gauge to compare actual performance against a management objective or the parameters of a management level.
Regional Medical Commands	Command-and-control headquarters that allocates resources, oversees day-to-day management, and fosters readiness among HCAs in their area
Regulated Medical Items	Materiel identified in the AMDF or FEDLOG or UDR with an AAC A. Examples would be MES, patient-movement items, and ASIOE.
Regulated Medical Waste	Includes liquid or semi-liquid blood or other potentially infections materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potential infectious materials during handling; contaminated sharps; and pathological and microbiological waste containing flood or other potentially infectious materials.
Rented Equipment	Requires legal documentation and accountability. Coordination with the contracting officer and PBO is mandatory.
Risk Mitigation Plan	A document that details the analysis of current or alternative logistics automated information systems (AISs) in comparison to DOD Migration AISs with intent of eliminating, minimizing or containing the negative effects of system migration in terms of cost, schedule and performance.
Sanitized	Articles made free of dirt, filth, bacteria, and other foreign agents that may or will endanger health or cause infection, illness, or disease.
Service-unique medical equipment sets	A grouping of medical and other items under a single NSN, with components, Service-managed.
Soiled Linen	Consists of laundry, considered contaminated and has been soiled with blood or other potentially infectious materials or may contain sharps. Handled IAW OSHA Bloodborne Pathogen Rule.
Total Package Fielding	The Army's method of fielding a system, end items, and all required support materiel identified, consolidated into a single package and funded by the fielding command responsible for fielding medical systems or end items under total package concepts.

Term	Definition
Textile services management	The inventory management, handling, transportation, laundering, infection control and occupational safety considerations applicable to the management of textile services in the AMEDD patient care facilities.
Type I complaint	Initiated when materiel (including equipment items) is determined by use or test to be harmful or defective to the extent that its use has caused or may cause death, injury, or illness. Immediate action will be taken to report such items and suspend them from use.
Type II complaint	Initiated when medical materiel other than equipment is suspected of being harmful, defective, deteriorated, or otherwise unsuitable for use. Expeditious action will be taken to report these items and suspend them from use.
Type III complaint	Initiated when equipment is determined to be unsatisfactory because of malfunction, design, or defects (attributable to faulty materiel workmanship and/or quality inspection or performance). Does not necessarily require suspension of the item.

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